APEA-AFT Health & Welfare Trust

Employee Benefit Plan

Juneau Education Support Staff

Effective Date: March 1, 2006
Restatement Date: September 1, 2016

APEA-AFT Health and Welfare Trust

Physical: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing: PO Box 34203, Seattle, WA 98124
Phone: (206) 441-7574 or (800) 732-1121 • Fax: (206) 505-9727 • Website www.apea-afttrust.com

Administered by
Welfare & Pension Administration Service, Inc.

March 18, 2020

To: **All Eligible Plan Participants and Dependents of the The APEA-AFT Health & Welfare Trust**

RE: **Response to Coronavirus (COVID-19) Outbreak**

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The world, as well as the United States is presently experiencing an outbreak of Coronavirus, known as COVID-19. You may have also heard that some states are issuing emergency orders requiring all insured health plans to take certain steps to cover services related to COVID-19 testing. Even though this Plan is not required to comply with the emergency order, the Board of Trustees of the APEA-AFT Health & Welfare Trust ("the Plan") is closely monitoring governmental recommendations and mandates.

In response to the Coronavirus Outbreak effective March 1, 2020 the Board of Trustees has adopted the following changes to the Plan's Medical and Prescription Drug Benefits which will stay in effect until the COVID-19 emergency orders are lifted:

- The Trust will temporarily waive any out-of-pocket costs associated with diagnostic testing for COVID-19 for both PPO and non-PPO providers. At this time, the waiver only applies to the test. For those testing positive, treatment of COVID-19 will still be subject to applicable cost sharing and PPO/non-PPO benefits depending on the provider's status.
- Crisis Response Lines and 24/7 access to the Aetna Nurse Medical Line are available to all participants at 1-800-556-1555.
- CVS/Caremark is **temporarily relaxing refill-too-soon guidelines** on 30-day maintenance medications at any in-network pharmacy. You are encouraged to keep at least a 30-day supply of prescription medication at hand. You may also choose to use mail order to receive delivery of your medications at home.

Active participants and their eligible dependents have access to **Teladoc** for 24/7 care via telephone at (800) 835-2362 or video chat at no cost to you. A Teladoc doctor can discuss any symptoms you are having and help determine the right treatment or next steps, including providing a prescription if appropriate. Please visit Teladoc.com for more details.

If you have questions about COVID-19, you may call the Alaska 2-1-1 hotline (800-478-2221 if you live in an area without the 2-1-1 line). If you have symptoms of COVID-19, please call Teladoc or your regular healthcare provider. If you are seriously ill, go to the emergency department. If you have a cough, fever, or shortness of breath, you may be asked to wear a mask immediately upon arrival.

The best way to protect yourself and others is to avoid being exposed to this virus.

- **Clean your hands often**. Wash your hands with soap and water for at least 20 seconds, especially after being in a public place or after blowing your nose, coughing, or sneezing.
- **Avoid close contact with other people**.
- **Stay home if you are sick**.
- Older adults and people who have severe chronic medical conditions (like heart or lung disease or diabetes) may be at higher risk for developing more serious complications from COVID-19. Please talk with your health care provider about additional steps you may take to protect yourself.

If you have any questions regarding the contents described in this notice, please contact the Administration Office at (800) 331-6158, option 0. Please also reference the trust website, apea-afttrust.com, for additional notices.

If you have questions about your prescription drug benefits, please contact Caremark Customer Service at (866) 818-6911.

Board of Trustees
The APEA-AFT Health & Welfare Trust

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Coronavirus
Frequently Asked Questions

What is coronavirus?
Coronavirus (2019-nCoV) is a respiratory illness caused by a virus that was first identified in China and it is highly contagious. The virus can be similar to the common cold, but some cases are more severe and could potentially be life-threatening.

What are the symptoms?
The most common symptoms are fever, cough, and shortness of breath, but occassionally symptoms are more severe. If you develop these or any flu-like symptoms, contact Teladoc to talk about your symptoms, travel history, and recent contact with anyone who may be infected with the virus.

What is the current risk in the U.S.?
While the risk outside China is currently low, additional cases have been identified in a growing number of other international locations, including the U.S. It is likely that person-to-person spread will continue, so more cases are expected to be identified.

How is coronavirus spread?
The virus can spread from person to person primarily through coughing and sneezing. Washing hands, cleaning commonly touched surfaces, and avoiding sick people are the best ways to prevent the illness from spreading.

How do I know if I'm at risk of contracting coronavirus?
You may be at greater risk if you have recently traveled to regions where there are currently outbreaks of the virus or if you come into contact with someone who has the virus. Symptoms typically appear within 2 to 14 days after exposure.

Is there a vaccine?
There is no vaccine for coronavirus at this time.

What should I do if I think I have coronovirus?
Because it is a virus, there is no cure, but Teladoc doctors can evaluate your risk and help with next steps when necessary. If it is determined that you have a different virus, our doctors can provide support to help relieve your symptoms.

Talk to a doctor 24/7

Visit Teladoc.com/Aetna | Call 1-800-835-2362

Download the app Download on the App Store GET IT ON Google Play

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APEA-AFT Health and Welfare Trust

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Phone: (206) 441-7574 or (800) 732-1121 • Fax: (206) 505-9727 • Website www.apea-afttrust.com

Administered by
Welfare & Pension Administration Service, Inc.

October 8, 2019

TO: All Eligible Participants and Beneficiaries
APEA-AFT Health and Welfare Trust

RE: Important Changes to Your Health Summary of Material Modification

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read this notice carefully and keep it with your benefit booklet for future reference.

Effective January 1, 2020, the following changes will be made to your health plan.

Coverage for Mental Health and Substance Abuse Treatment

Mental Health and Substance Abuse Treatment will be covered like any other condition, subject to deductibles, coinsurance, and all other plan provisions, including preauthorization requirements for all inpatient services. Plan participants have requested coverage for these conditions, and the Trustees are pleased to offer this benefit enhancement.

Prescription Drug Cost Effectiveness Plan Design Program

The Plan will also implement a Cost Effectiveness Plan Design program. This program only applies to new medications on the market or new indications for existing medications. This will not impact any medication you are currently using.

The Plan will exclude from coverage any new drug or any new indication for an existing drug approved by the FDA with an incremental cost-effectiveness ratio greater than:

- $100,000 per additional quality-adjusted life-year for drugs not indicated in rare conditions
- $150,000 per additional quality-adjusted life-year for drugs indicated in rare conditions, unless the drug or indication has been granted breakthrough therapy designation by the FDA.

The Plan or CVS/Caremark determines which drugs or indications exceed the incremental cost-effectiveness ratio threshold using the following resources:

- Reports issued by the Institute for Clinical and Economic Review or similar organization
- Peer-reviewed, published cost-effectiveness analysis
- Consultation with qualified health care professionals
- Other unbiased sources

If you have questions about your prescriptions or coverage, log into caremark.com or call 866-818-6911 (toll-free).

Grandfathered Plan Notice

This Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office at 206-441-7574, option 0 or toll free at 800-331-6158, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions regarding the information outlined in this notice, please contact the Administration Office at (206) 441-7574 or (800) 331-6158, option 0.

Board of Trustees
APEA-AFT Health and Welfare Trust

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Administered by
Welfare & Pension Administration Service, Inc.

November 21, 2018

TO: All Eligible Participants and Beneficiaries
APEA-AFT Health and Welfare Trust

RE: Summary of Material Modification

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read this notice carefully and keep it with your benefit booklet for future reference.

Effective November 1, 2018, the following language will be added after the "Appointment of Authorized Representative" section on page 46 of your current Benefit Plan Booklet:

Anti-Assignment

No Covered Person shall at any time, either during the time in which he/she is a covered participant in the Plan or following his/her termination as a covered participant, in any manner have any right to assign his/her right to sue or recover benefits under the Plan, to enforce rights due under the Plan to appeal a denial of benefits, or to any other causes of action which he/she may have against the Plan or its fiduciaries.

Grandfathered Status

This Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office at 206-441-7574, option 0 or toll free at 800-331-6158, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions regarding the information outlined in this notice, please contact the Administration Office at (206) 441-7574 or (800) 331-6158, option 0.

Board of Trustees
APEA-AFT Health and Welfare Trust

The APEA-AFT Health & Welfare Trust
Employee Benefit Plan

JESS

Amendment Number 2
to the September 2016 SPD Restatement

Effective January 1, 2017

The APEA-AFT Health & Welfare Trust Employee Benefit Plan is hereby amended as follows:

The Plan shall adopt the Caremark Advanced Control Formulary. No payment shall be made for medications which are listed as excluded on the Advance Control Formulary.

The following language shall be added to the Plan:

Formulary refers to a list of covered drugs that serves as a guide within select drug classes for you and your doctor. The formulary is managed by the Prescription Benefits Manager. Non-formulary drugs are not included on the drug list and may be considered non-preferred or excluded. If a drug is not on the list then it may not be covered or may cost you more. You may be responsible for the full cost of a non-formulary drug. The formulary is subject to change in response to market dynamics. An appeals exception process is available to accommodate medical necessity circumstances.

Signed:

[signature]	10-24-16	Chair
Authorized Signature	Date	Title
[signature]	10-24-16	Trustee
Authorized Signature	Date	Title

The APEA-AFT Health & Welfare Trust
Employee Benefit Plan

JESS

Amendment Number 1
to the September 2016 SPD Restatement

Effective January 1, 2017

The APEA-AFT Health & Welfare Trust Employee Benefit Plan is hereby amended as follows:

Aetna will replace Multiplan as the Nationwide PPO Network.

Signed:

Authorized Signature	Date: 10-24-16	Title: Chair
Authorized Signature	Date: 10-24-16	Title: Trustee

PLAN CONTACTS

Plan Website	www.apea-afttrust.com
Plan Administrative Office	APEA-AFT Health & Welfare Trust 211 Fourth Street, Suite 306 Juneau, AK 99801 907-789-0182
Claims Administrator	Welfare & Pension Administration Service, Inc. 2815 Second Avenue, Suite 300 PO Box 34203 Seattle, WA 98124-1203 800-331-6158 www.wpas-inc.com
Prescription Benefits Manager:	CVS Caremark 750 West John Carpenter Freeway, Ste. 500 Irving, TX 75039 (866) 818-6911 www.caremark.com Mail Order: PO Box 94467 Palatine, IL 60094-4467 Paper Claims: PO Box 52136 Phoenix, AZ 85072-2136
Vision Program	VSP – out of network claims Mail out-of-network claims to: PO Box 385018 Birmingham, AL 35238-5018 (800) 877-7195 www.vsp.com
Utilization Review and Case Management Provider	Medical Rehabilitation Consultants 111 W Cataldo Ave Spokane, WA 99201 (800) 827-5058
Preferred Provider Facility In Anchorage	Providence Alaska Medical Center 3200 Providence Drive Anchorage, AK 99508 907-562-2211
Preferred Provider Facility In Mat-Su Valley	Mat-Su Regional Medical Center 2500 S. Woodworth Loop Palmer, AK 99645 907-861-6000 www.matsuregional.com
Coalition Health Center	Coalition Health Center 2741 Debarr Road, Suite C210 Anchorage, AK 99508 (907) 265-1370 www.coalitionhealthcenter.com

Nationwide Preferred Provider Network:	Multiplan (800) 877-1444 www.multiplan.com
Telemedicine Provider:	Teledoc (800) Teledoc (835-2362) www.teledoc.com

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INTRODUCTION

The Board of Trustees of the APEA-AFT Health & Welfare Trust has established the Plan for the benefit of eligible Employees, on the terms and conditions described herein.

The Plan's purpose is to help to offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Illness. Through careful use of the Plan, you, as a consumer of health care, can have a direct impact on the cost of the Plan. This will benefit you by allowing the Plan to continue to provide this high quality level of benefits.

The purpose of this Summary Plan Description is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for health care services. These benefits are subject to change as determined by the Board of Trustees. The Board of Trustees is the Plan fiduciary and has full authority to administer the Plan consistent with its terms, and to interpret any ambiguity in those terms.

Health Care Reform Notice:
This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that our plan does not include all identical requirements found in non-grandfathered plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other requirements in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which requirements apply and which requirements do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 907-789-0182. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

This Plan Document and Summary Plan Description (the "Summary Plan Description"), made by the Board of Trustees of APEA-AFT Health & Welfare Trust (the "Board of Trustees") as of September 1, 2016, hereby amends and restates the APEA-AFT Health & Welfare Trust Employee Benefit Plan (the "Plan"), which was originally adopted by the Board of Trustees, effective March 1, 2006.

The Board of Trustees, as the settlor of the Plan, hereby adopts this Summary Plan Description as the written description of the Plan. This Summary Plan Description amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Summary Plan Description to be executed.

APEA-AFT Health & Welfare Trust

SCHEDULE OF BENEFITS

MEDICAL BENEFITS	
Deductible, per Calendar Year	$800 per Individual $2,400 per Family
Out-of-Pocket Maximum, per Calendar Year (excluding deductible)	$1,500 per Individual $4,500 per Family
Annual and Lifetime Maximum Benefits	Unlimited
Benefit Percentages (Based on Allowable Charges) and Calendar Year Maximums	
Acupuncture	80%, 12 visits allowed
Emergency Room Expenses – Calendar Year Deductible Waived	$50 ER deductible, waived if admitted to the Hospital, then 80% No coverage for non-emergency services
Coalition Health Center	$0 copay for preventive services $10 copay for all other services
Hearing Aid Expense	80%, up to $800
Home Health Care	80%, 130 visits allowed
Hospice Care - Inpatient	10 days allowed 80% PPO Facility 80% Out-of-Area Facility 50% Non-PPO Facility
Hospice Care – Outpatient	80%, 6 months allowed
Hospital Charges	80% PPO Facility 80% Out-of-Area Facility 50% Non-PPO Facility
Mental or Nervous Conditions	No coverage
Outpatient Dialysis Treatment	80% of the Usual and Reasonable Charge
Preventive Care Services	100%, not subject to the deductible
Private Duty Nursing	80%, 70 visits allowed

Rehabilitation Therapy Massage Therapy Physical Therapy Occupational Therapy	80%, 45 visits allowed for all services combined
Skilled Nursing / Convalescent Care Facility	120 days allowed 80% PPO Facility 80% Out-of-Area Facility 50% Non-PPO Facility
Substance Abuse Treatment	No coverage
Transplant-Related Travel and Lodging	80%, up to $50 per night, $10,000 per transplant period
All Other Travel	Up to $600 for transportation expense Up to $150 per day for lodging Annual maximum of 7 days lodging
All Other Covered Services	80%

PRESCRIPTION DRUG BENEFITS	
Calendar Year Deductible	$500 per Individual
Retail Copays (per 30 day supply)	
Generic	$10 (no deductible)
Preferred Brand	$25
Non-Preferred Brand	$45
Mail Order Copays (up to a 90 day supply)	
Generic	$20 (no deductible)
Preferred Brand	$50
Non-Preferred Brand	$90
Pre-authorization is required for Specialty drugs and Specialty medications are limited to a 30-day supply. Step-therapy for some specialty drugs may apply.	

DENTAL BENEFITS	
Deductible, per Calendar Year	$50 per Individual $150 per Family
Calendar Year Maximum Benefit	$2,000 per Individual
Benefit Percentages (Based on Allowable Charges)	
Diagnostic and Preventive	100%, not subject to the deductible
Restorative	80%
Reconstructive	50%

VISION BENEFITS (ADMINISTERED THROUGH VSP)	
Copay	$25
Eye Exam	Every 12 months
Lenses	Every 24 months
Frames	Every 24 months
Benefits are limited to the Network and Non-VSP provider allowances	

PREFERRED PROVIDER ORGANIZATIONS (PPOs)

The Plan has negotiated discounts for Covered Persons through Preferred Provider Organizations (PPOs). Benefits and out-of-pocket requirements vary if covered services are obtained from a PPO provider versus a non-Preferred (non-PPO) Provider or an out-of-area provider. PPO provisions may not apply to dialysis claims. Please see the Outpatient Dialysis Treatment provisions for more information.

PPO Providers
Allowable Charges will be reimbursed according to the Schedule of Benefits for Medically Necessary Covered Expenses. For providers who participate in the PPO, the allowable charge is the discounted fee that the providers have agreed to accept under our agreements with them, except as provided by the Outpatient Dialysis Provision. PPO providers will seek payment from the Plan when they provide services to you. You will be responsible for any applicable deductibles, copayments, coinsurance, charges in excess of stated benefit maximums and charges for services or supplies not covered under the Plan. These amounts will be reflected on the "Explanation of Benefits" sent to you.

- The PPO Hospital within the Municipality of Anchorage is **Providence Alaska Medical Center**.
- **Mat-Su Regional Medical Center** is the PPO Hospital in the Mat-Su Borough.
- **Beech Street / Multiplan** is the nationwide PPO network for the Plan, for all services other than Hospital services in the Municipality of Anchorage or the Mat-Su Borough. You can access a list of PPO providers at www.beechstreet.com.

Please note: PPO providers are subject to change. Please verify a providers' participation as a PPO before obtaining services.

You have a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. You, together with your Physician, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO providers are independent contractors; the Plan makes no warranty as to the quality of care that may be rendered by any PPO provider.

Non-PPO Providers
When you use a Non-PPO provider, Allowable Charges will be paid at the Usual, Customary and Reasonable level and no discount will be given. You will be responsible for any applicable deductibles, copayments, coinsurance, charges in excess of stated benefit maximums, charges above UCR, and charges for services or supplies not covered under the Plan. These amounts will be reflected on the "Explanation of Benefits" sent to you.

Exceptions will be made under the following circumstances:

- If you must be taken to the nearest facility available for an Accident or Emergency; or
- If services are not available at a PPO facility.

Covered Persons Who Live Out-of-Area
If you live more than 25 miles outside the PPO service area, you are considered "out-of-area." This means that the Plan does not have agreements with PPO providers in your area. You may come into the PPO service area for services and receive benefits at the PPO provider level. If you come into the PPO service area for services and use a non-PPO Provider, your benefits will be paid at the non-PPO provider level.

Covered Expenses for services received from an out-of-area acute-care Hospital will be reimbursed at the Out-of-Area benefit percentage.

COST CONTAINMENT PROVISIONS

The Utilization Review (UR) and Case Management (CM) program administrator is:

Medical Rehabilitation Consultants (MRC)
800-827-5058

Medical Rehabilitation Consultants has trained medical staff, Physicians and specialists who review and certify, in advance, hospitalizations and surgeries. Think of them as your medical consumer advocates.

UR is designed to help you make informed decisions about your medical care. It also helps you to use your group health benefits in the most cost-effective manner possible. By pointing out the alternatives that may be available to you, the program can help you to avoid unnecessary or more expensive medical procedures. To benefit from UR, certification from Medical Rehabilitation Consultants must be obtained before you receive certain treatments or services listed below. Participation in the UR program is your responsibility.

Whenever possible, notify Medical Rehabilitation Consultants ahead of time for medical care that requires certification under this program. You may call Medical Rehabilitation Consultants yourself or have your doctor, a relative, friend, or any other person call for you; however, it is your responsibility to make sure that the call is made.

The UR program administrator will not interfere with your course of treatment or the Physician- patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this program.

Pre-certification and post-certification are not a guarantee of eligibility or payment of benefits. It only means that the Plan or its authorized representative has confirmed that your Hospital admission meets Inpatient Hospital admission criteria for a given number of days. Payment of benefits is based on the provisions of this Plan and your eligibility for coverage at the time the expense is incurred.

Utilization Review Requirements
The following is an explanation of the services that require certification:

Hospital Admissions
Notify Medical Rehabilitation Consultants at least ten business days, or as soon as possible, before non-Emergency Hospitalization to obtain certification of Medical Necessity for the admission, including the number of days of Hospital Confinement.

Emergency Admissions
When you are admitted to any Hospital on an Emergency basis, notify Medical Rehabilitation Consultants within two business days after admission (or as soon as possible after admission) to obtain certification, including the number of days of Hospital Confinement. In any event, notify Medical Rehabilitation Consultants before discharge.

Do not delay seeking medical care for any Covered Person who has a serious condition that may jeopardize his life or health because of the requirements of this program. For urgent, Emergency admissions, follow your Physician's instructions carefully, and contact Medical Rehabilitation Consultants within the time limit specified above.

Since the Plan does not require you or a covered Dependent to obtain approval of a medical service prior to getting treatment for an urgent care or Emergency situation, there are no "Pre-service Urgent Care Claims" under the Plan. In an urgent care or Emergency situation, you or a covered Dependent simply follow the Plan's procedures following the treatment and file the claim as a "Post-service Claim."

Additional Hospital Days
If your doctor believes that it is necessary for you to stay in the Hospital longer than the number of days that were originally certified, notify Medical Rehabilitation Consultants again to obtain certification for additional days.

Additional Services Requiring Certification
Notify Medical Rehabilitation Consultants at least ten business days, or as soon as possible, before non-Emergency receipt of services or purchase of supplies listed below. If you require any of the following services on an Emergency basis, notify Medical Rehabilitation Consultants within two business days following the receipt of services or supplies, or as soon thereafter as possible.

- Outpatient Surgeries
- Home Health Nursing, including the associated Physical Therapy and Occupational Therapy
- Hyperbaric Oxygen Treatments
- Diagnostic radiology (excluding x-rays) CT, MRI, MRA and PET scans
- Skilled Nursing Facility Services
- Travel

Individual Case Management

Individual Case Management is a program to assist patients who suffer a long-term Illness or Injury. The Medical Rehabilitation Consultants case managers follow cases that require extended Hospital stays or on-going medical attention. Their goal is to work with the medical providers to help assure that all necessary services are provided while the patient's health benefit dollars are used as efficiently as possible.

Through early notification from utilization review nurses, case management can promptly become involved in potentially catastrophic cases and serve as a vehicle to significantly reduce the cost of catastrophic claims. The Medical Rehabilitation Consultants case manager becomes the patient's advocate. Patients and their families are often confused by the complexities of medical treatment and the variety of providers. This is a time when a patient whose Illness or Injury requires long-term or costly medical care needs a case manager who can provide emotional support and help coordinate services such as home health care or a Hospice Care Program.

Each of the Medical Rehabilitation Consultants case managers is a Registered Nurse. When requested to provide medical case management services, the Medical Rehabilitation Consultants case managers help to coordinate the attending Physician's plan of care, including the services of Physicians, nurses, Hospital social workers and Home Health Care Agencies. Most people prefer to recuperate at home rather than in a Hospital setting and, if medical care can be provided in the home rather than the Hospital, the Medical Rehabilitation Consultants case manager works with the Hospital's discharge planner and the patient's Physician to make the necessary arrangements for the home care. They help to arrange for such services as Physical Therapy, home nursing care, medical equipment or medication/drug treatment. The Medical Rehabilitation Consultants case managers also help obtain discounts on drugs, equipment and other services. They work with the patients and families to lessen the emotional trauma of serious Illness by addressing questions or concerns as they arise.

Medical Rehabilitation Consultants case managers also have access to the Medical Rehabilitation Consultants network of Physician advisors. These Physicians are board certified in various medical specialty areas. They serve as a valuable medical resource and are available for discussion with the case management nurses as well as the treating Physicians.

Alternate Course of Treatment
At the recommendation of the case manager, the Plan may determine that a service or supply, not otherwise listed for coverage under this Plan, be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply.

If a Covered Person, in cooperation with his or her provider, elects a course of treatment that is deemed by the Plan to be more extensive or costly than is necessary to satisfactorily treat the Illness or Injury, this Plan may allow coverage for the reasonable and appropriate value of the less costly or extensive course of treatment.

ELIGIBILITY AND ENROLLMENT;
COMMENCEMENT AND TERMINATION OF COVERAGE

Eligibility for Individual Coverage
Newly hired employees shall be eligible to enroll on the first day of the month following a 60-day waiting period. In the event the employee is initially employed on a probationary period, the first month of such probationary period will be considered an orientation period and the waiting period shall commence following the orientation period.

A person who is an eligible Employee of more than one Participating Employer shall be covered as the Employee of only one employer. An Employee must actually begin work for the Participating Employer in order to be eligible.

"Employee" shall mean a person who is a regular employee of the Participating Employer, regularly scheduled to work at least 20 hours per week, or at least 4 hours per day, for the Participating Employer in an employer-employee relationship, and who meets the eligibility requirements of this Plan.

Eligibility for Dependent Coverage
Each Employee will become eligible to enroll for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage of a Dependent as a Covered Person;

2. The date coverage for his or her Dependents first becomes available under the Plan; and

3. The first date upon which he or she or she acquires a Dependent.

"Dependent" shall mean:

1. The Employee's legal spouse, who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract or common law certification in the state of marriage of such parties.

2. The Employee's Child who is less than 26 years of age, including:

    a. Natural children and legally adopted children, or

    b. Step-children, foster children placed through a State foster child program, or children for whom you are the legal court-appointed guardian.

A covered Dependent Child who attains the limiting age while covered under the Plan shall remain eligible for medical benefits if ALL of the following exist at the same time:

1. He or she is mentally or physically handicapped;

2. He or she is incapable of self-sustaining employment;

3. He or she is dependent on the covered Employee for at least 50% of his or her support and maintenance; and

4. He or she is unmarried.

The Employee must furnish satisfactory proof to the Plan that the above conditions continuously exist on and after the date the limiting age is reached. The Plan may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the Plan, the Child's coverage shall cease on the date such proof is due.

The term Dependent excludes:

1. A spouse who is legally separated or divorced from the Employee. Such spouse must have met all requirements of a valid separation agreement or divorce decree in the state granting such separation or divorce; or

2. Any person on active military duty.

Effective Date of Employee Coverage
If completed enrollment forms are received by the Plan within 31 days of the date of eligibility, the Employee's coverage shall become effective at 12:01 A.M. on the date of eligibility. If an Employee fails to enroll within 31 days of eligibility, enrollment can occur only under the conditions specified under the sections entitled "Special Enrollment" or "Open Enrollment"**.**

If an eligible Employee is not Actively at Work due to a reason other than a medical condition on the date his or her coverage would otherwise become effective, coverage shall become effective on the day he or she returns to Active Employment.

Effective Date of Dependent Coverage
Coverage for Dependents will be effective at 12:01 A.M. on the earliest of the following dates:

1. On the Employee's effective date, if the Employee enrolls the Dependents at the same time as the Employee's initial enrollment;

2. From the moment of birth for the first 31 days for a Newborn Dependent Child, or a Child who is adopted or placed for adoption. If an Employee wishes to continue coverage beyond this 31-day period, the Employee must enroll the Child **during the first 31-day period from birth** and elect the appropriate level of coverage; or

3. On the first day of eligibility, the Employee enrolls the Dependent and elects the appropriate level of coverage within 31 days of the date the Dependents become eligible for coverage.

If an Employee fails to enroll a Dependent within 31 days of eligibility, enrollment can occur only if the Employee experiences a Qualifying Event**.**

A Dependent's effective date may not be prior to the Employee's effective date of coverage.

Employees Returning from Leave Without Pay
If you were covered by the Plan prior to going on leave without pay, when you return to work you are covered starting the later of the first day back at work or the first day of the coverage period for which the employer and employee contributions are received.

Employees Returning from Layoff
If you were covered by the Plan prior to going on layoff and you return to work within two years, when you return to work you are covered starting on the first day of the month following your return to work provided both you and your employer make the required contribution for your coverage. Your dependents are eligible at the same time.

Qualifying Events
Normally, changes cannot be made outside of Open Enrollment. However, if you experience a qualifying event at any other time of the year, you may change your benefits by contacting the Plan and making a new election within 31 days of the qualifying event. If you fail to change your election within 31 days of a qualifying event, you will have to wait until the next Open Enrollment to make a change. If you do not have supporting documentation such as a birth certificate, marriage license or Social Security number you may enroll your dependent and submit the document to the Plan at a later date. Although claims cannot be processed without the required documents, you should not delay enrolling your dependent in order to meet the 31 day deadline. If you change your election as a result of a qualifying event, the change will be effective on the 1st of the month after the Plan receives your new election form.

Qualifying events include:

- Marriage
- Birth or adoption of a Child
- Divorce or legal separation
- Death of a Dependent
- Dependent ceases to be eligible or gains eligibility
- Loss, gain, or significant change in your Dependent's coverage.
- Declaration of an open enrollment period by the Board of Trustees

Special Enrollment Due to Coverage under Medicaid or under a State Children's Health Insurance Program (CHIP)
If an Employee or eligible Dependent did not enroll in the Plan when initially eligible, but was otherwise eligible to enroll, they will be permitted to later enroll in the Plan under one of the following circumstances:

- The Employee or eligible Dependent was covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently terminates; or
- The Employee or eligible Dependent becomes eligible for a premium assistance subsidy under Medicaid of CHIP subsequent to the time they were initially eligible.

The Employee or Dependent must request enrollment in the Plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days after their eligibility for a premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable.

Open Enrollment
A period prior to the beginning of each Plan Year has been designated as an annual open enrollment period during which an Employee can elect coverage and add or delete any Dependents. Changes made during Open Enrollment will be effective at the beginning of the next Plan Year (September 1).

Qualified Medical Child Support Orders
The Plan shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an Eligible Dependent. The Claims Administrator has the authority to interpret the Medical Child Support Order for purposes of determination of whether it meets the requirements of a QMCSO as defined by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan shall, as soon as administratively possible:

1. Notify the Covered Person and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan shall:

1. Notify the state agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:

    a. Whether the Child is covered under the Plan; and

    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

When Coverage Ends
Coverage will end without notice at 11:59 P.M. on the earliest to occur of the following dates:

1. On the date of termination of the Plan;

2. On the date of the expiration of the last period for which a contribution was made, in the event of a failure to make a contribution when due;

3. On the last day of the month in which the Employee ceases to be eligible for coverage under the Plan;

4. For Dependents, on the last day of the month in which he or she ceases to be eligible for coverage under the Plan as a Dependent;

5. For Dependents, on the date of termination of Dependent Coverage under the Plan; and

6. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Please note: An Employee must notify the Claims Administrator or the Plan immediately when an enrolled Dependent is no longer eligible to be enrolled in the Plan. If notice is not provided, the Plan, in its sole discretion, will determine the date on which coverage terminated according to the provisions of this Plan. Any claims paid by the Plan that were Incurred after the termination date will be subject to reimbursement according the "Right of Recovery" provision.

Continuation during FMLA Leave
The Plan will at all times comply with FMLA. During any leave taken under FMLA, you may maintain coverage under this Plan on the same conditions as if you had been continuously employed during the entire leave period. To continue your coverage, you must comply with the terms of the Plan, including election during the Plan's open enrollment period, and pay your contributions, if any. Contact the Participating Employer for information concerning your eligibility for FMLA.

Continuation during USERRA Leave
If you are absent from employment because you are in the Uniformed Services, you may elect to continue your coverage under this Plan for up to 24 months. To continue coverage, you must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay your contributions, if any. In addition, USERRA also requires that, regardless of whether you elected to continue your coverage under the Plan, your coverage and your dependents' coverage be reinstated immediately upon your return to employment, so long as you meet certain requirements contained in USERRA.

CONTINUATION OF COVERAGE UNDER COBRA

Introduction
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

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

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

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

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

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

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

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan has been notified that a qualifying event has occurred. The employer must notify the Plan of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the Employee; or
- The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the Employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan within 60 days after

the qualifying event occurs.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

Are there other coverage options besides COBRA Continuation Coverage?

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

MAJOR MEDICAL BENEFITS

Deductibles
A Deductible is a specified dollar amount of Covered Expenses you must incur during a Calendar Year before any other Covered Expenses can be considered for payment at the Benefit Percentages stated in the Schedule of Benefits of this Plan. The amount credited toward a Deductible will not exceed the allowable charge for the covered service or supply.

Covered Expenses that are incurred during the last three months of a Calendar Year which are applied to an individual's Deductible for that Calendar Year will also be allowed as credit toward the Deductible amount in the next Calendar Year.

Covered Expenses
Covered medical expenses are the Usual, Customary and Reasonable expenses Incurred by or on behalf of a Covered Person for the Hospital or other medical services listed below which are:

1. Ordered by a Physician;

2. Medically Necessary for the treatment of the Illness or Injury; and

3. Eligible for payment under the Plan.

Benefit Percentage
The Benefit Percentage is the percentage of Covered Expenses, in excess of the Deductible amount, which the Plan pays. The Benefit Percentage is listed in the Schedule of Benefits.

Covered Major Medical Benefits
Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Acupuncture.** Charges for acupuncture services performed by a Physician as a form of anesthesia for a covered surgical procedure, or for treatment of chronic pain.

   For the purposes of acupuncture services, a Physician will include an acupuncturist certified by the American Association of Acupuncture and Oriental Medicine, who is practicing within the scope of both his certification and the laws of the jurisdiction where treatment is given.

2. **Ambulance.** Charges for transportation by professional ambulance, including approved available air and train transportation (excluding chartered air flights), to a local Hospital or transfer to the nearest facility having the capability to treat the condition.

3. **Anesthesia.** Charges for the cost and administration of an anesthetic.

4. **Birthing Center.** Charges for the services of a Birthing Center for Medically Necessary care provided within the scope of its license.

5. **Blood.** Charges for processing and administration of blood or blood components, excluding the cost of the actual blood or blood components if replaced.

6. **Chemotherapy.** Charges for chemotherapy and radiation therapy.

7. **Chiropractic Care.** Charges for spinal adjustment and manipulation, X-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Schedule of Benefits.

8. **Contraception Expenses.** Charges for contraceptive drugs (not covered elsewhere under the Plan) and devices which require a Physician's prescription and which are approved by the FDA. Examples include injectables (such as Depo-Provera), implants (such as Norplant), and Intrauterine Devices

(IUDs). Covered Expenses include consultations, exams, procedures and other related medical services and supplies.

9. **Dental.** Charges for dental services rendered by a Physician or Dentist for the treatment of an Injury to the jaw or to the natural teeth, including the initial replacement of these teeth, and any necessary dental X-rays for the Injury, providing treatment is rendered during the Calendar Year in which the Accident occurred, or the next following Calendar Year. Treatment not rendered within this time period will not be covered under this benefit. Charges for anesthesia and facilities associated with dental services are covered if such services are required because of the Covered Person's condition.

10. **Diabetes Education.** Charges in connection with an outpatient self-management training or education program for diabetes, and medical nutrition therapy, if diabetes treatment is prescribed by a health care Provider. Coverage for the cost of diabetes outpatient self-management training or education and for the cost of medical nutrition therapy is only allowed if provided by a health care Provider with training in the treatment of diabetes. "Diabetes" includes insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes.

11. **Diagnostic Tests; Examinations.** Charges for X-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures to diagnose a symptomatic Illness or Injury.

12. **Durable Medical Equipment.** Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin-Dependent diabetics. DME includes associated supplies for the necessary function of any equipment. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for:

    a. Repairs;

    b. Replacements for equipment still under warranty; or

    c. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment."

13. **Hearing Aids and Hearing Examinations.** Charges for a routine hearing exam performed by a Physician, or an audiologist who is certified in audiology and is supervised by a Physician, and charges for a non-disposable electronic hearing device (including mold) and installation, in accordance with a written prescription by a Physician, subject to the limits stated in the Schedule of Benefits.

14. **Hemodialysis.** Charges for hemodialysis.

15. **Home Health Care.** Charges by a Home Health Care Agency for:

    a. Registered Nurses or Licensed Practical Nurses;

    b. Certified home health aides under the direct supervision of a Registered Nurse;

    c. Registered therapist performing physical, occupational or Speech Therapy;

    d. Physician calls in the home; and

    e. Services, drugs and medical supplies which are Medically Necessary for the treatment of the Covered Person that would have been provided in the Hospital, but not including Custodial Care.

Each visit will count toward the Calendar Year visit maximum as listed on the Schedule of Benefits. **Please Note:** Transportation services are not covered under this benefit.

16. **Hospice Care.** Charges relating to Hospice Care provided the Covered Person has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Schedule of Benefits. Covered Hospice expenses are limited to:

    a. Room and Board for Confinement in a Hospice;

    b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;

    c. Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;

    d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);

    e. Home health aide services;

    f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;

    g. Medical social services by licensed or trained social workers, Psychologists or counselors;

    h. Nutrition services provided by a licensed dietitian;

    i. Respite care; and

    j. Bereavement counseling, which is a supportive service provided by the Hospice team to Covered Persons in the deceased's Family after the death of the Terminally Ill person, to assist the Covered Persons in adjusting to the death. Benefits will be payable up to 15 visits per Family if the following requirements are met:

        i. On the date immediately before his or her death, the Terminally Ill person was in a Hospice Care Program and a Covered Person under the Plan; and

        ii. Charges for such services are Incurred by the Covered Persons within 6 months of the Terminally Ill person's death.

17. **Hospital.** Charges made by a Hospital for:

    a. Inpatient Treatment

        i. Daily Semi-Private Room and Board charges;

        ii. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges; (3) General nursing services; and

        iii. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board

    b. Outpatient Treatment

        i. Emergency room;

ii. Treatment for chronic conditions;

iii. Physical Therapy treatments;

iv. Hemodialysis; and

v. X-ray, laboratory and linear therapy.

18. **Hospital Audit and Case Management Fees.** Charges for an independent audit of Hospital records to determine Medical Necessity, for an independent audit of Hospital billing accuracy, and for UR case management services that have been approved by the Plan, in its sole discretion, as being reasonable and necessary to the determination of coverage under the Plan. Such charges may include the reasonable cost by a Provider for photocopies of medical records requested by the Plan for the purpose of the independent audit or case management services.

19. **Massage Therapy.** Charges for massage are covered only when provided by or under the direct supervision of a Physician, up to the Rehabilitation Therapy maximum shown on the Schedule of Benefits.

20. **Mastectomy.** Charges in connection with a mastectomy will include the following:

    a. Reconstruction of the breast on which the mastectomy has been performed;

    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

    c. Prostheses and physical complications from all stages of mastectomy, including lymphademas;

    in a manner determined in consultation with the attending Physician and the patient.

21. **Maternity Inpatient Stays.** Charges in connection with Hospital Inpatient expenses related to the Pregnancy of a Covered Person. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a 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). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

22. **Newborn Care.** Charges for Hospital and Physician nursery care for Newborns who are natural Children of the Employee during the first 31-day period from birth. Benefits will be provided under the Child's coverage and the Child's own Deductible and Benefit Percentage provisions will apply. Covered Expenses include:

    a. Hospital routine care for a Newborn during the Child's initial Hospital Confinement at birth; and

    b. The following Physician services for well-baby care during the Newborn's initial Hospital Confinement at birth:

        i. The initial Newborn examination and a second examination performed prior to discharge from the Hospital; and

        ii. Circumcision.

    The Plan will cover a routine hearing exam during the first 30-day period from birth for a covered Dependent Child. A second exam will be covered if necessary to diagnose a condition identified during the initial hearing exam.

Benefits are also provided for Hospital and Physician nursery care for an Injury or Illness of Newborn as any other medical condition.

Please note: Coverage following the first 31-day period from birth will be available only **if the Newborn is properly enrolled in the Plan during the first 31-day period following birth**.

23. **Nursing Services.** Charges for services of a Registered Nurse or Licensed Practical Nurse.

24. **Obstetrical.** Physician's charges for obstetrical services are considered on the same basis as for an Illness, including the Covered Person's prenatal care; obstetrical and gynecological care rendered by a Nurse or Nurse Midwife.

25. **Occupational Therapy.** Charges for treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing Outpatient facility, up to the Rehabilitation Therapy maximum shown on the Schedule of Benefits.

26. **Oral Surgery.** Charges for Oral Surgery, limited to excision of neoplasms including benign, malignant and pre-malignant lesions, tumors or cysts, incision and drainage of cellulitis, surgical procedures involving accessory sinus, salivary glands and ducts.

27. **Oxygen.** Charges for oxygen and the rental of equipment for its own administration.

28. **Phenylketonuria (PKU).** Charges for the formulas necessary for the treatment of phenylketonuria.

29. **Physical Therapy.** Charges for treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed Outpatient therapy facility, up to the Rehabilitation Therapy maximum shown on the Schedule of Benefits.

30. **Physician Services.** Charges for services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.

31. **Preventive Care.** Charges for routine preventive care services for adults and children, based on age and risk factors. These services may include exams, cancer screening, immunizations, and routine lab and x-ray services.

32. **Prosthetics.** Charges for the initial placement of prosthetic devices.

33. **Radiation Therapy.** Charges for radiation therapy and treatment.

34. **Second Surgical Opinions.** Charges for second opinions for proposed surgical procedures which are covered under the Plan.

35. **Skilled Nursing.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility, up to the limits set forth in the Schedule of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) for which the Covered Person is confined, including:

    a. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis, such as general nursing services. If private room accommodations are used, the daily Room and Board charges allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross-section of similar institutions in the area;

    b. Medical services customarily provided by the facility, with the exception of the charges of

medical providers that are separately billed, including private duty or special nursing services and Physician's services; and

c. Drugs, biologicals, solutions, dressings and casts, furnished for use during the Convalescent Period, but no other supplies.

Your Physician must certify that 24-hour nursing service is Medically Necessary. Separate stays due to related causes will be treated as one if your stays are separated by less than three months.

36. **Speech Therapy.** Charges for Speech Therapy, by a Physician or qualified speech therapist, when needed due to an Illness or Injury (other than a functional nervous disorder) or due to surgery performed as the result of a Illness or Injury, excluding speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

37. **Surgery.** Charges for surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

    a. Multiple procedures adding significant time or complexity will be allowed at:

        i. 100% (full Usual, Customary and Reasonable value) for the first or major procedure; and

        ii. 50% for the second and subsequent procedures.

    b. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of the Usual, Customary and Reasonable allowance for the major procedure, and 50% for the secondary or lesser procedure.

    c. Charges made for services rendered by an assistant surgeon will be allowed at 25% of the Usual, Customary and Reasonable allowance for the primary procedure for the type of surgery performed.

38. **Telemedicine.** The plan will cover Teledoc or video consultations with a physician. Teledoc provides access to a national network of board-certified doctors and pediatricians in the U.S. who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication when necessary via phone or online video consultations. These services will be covered at 100%, not subject to the deductible.

39. **TMJ Syndrome**. Charges in connection with temperomandibular joint (TMJ) syndrome or dysfunction.

40. **Travel.** The plan will cover travel benefits based on the following:

    a. Travel must be pre-certified by the Claims Administrator; and

    b. The Illness, Injury, or condition cannot be treated locally and requires transfer to a Hospital or medical provider that has facilities for the treatment of the condition, or;

    c. The Incurred charges for the treatment at the non-local location must be equal to or less than the local Hospital or local medical provider charges.

    For Dependent Children under 18 years of age, the transportation expense for one adult will be allowed.

41. **Voluntary Sterilization**. Charges for services and supplies in connection with tubal ligation and vasectomy.

42. **Coverage for Organ and/or Tissue Transplants**

    The Plan strongly recommends that any covered person who is a candidate for any transplant procedure contact Utilization Review program administrator for a pre-authorization review before making arrangements for the procedure. This communication may identify certain types of procedures, or expenses associated with the procedures, which will not be covered under the Plan, before the actual services are rendered.

    The benefits under this Plan are available only when the transplant recipient is a Covered Person.

    - **Participating Transplant Centers**
      As a result of the pre-authorization review, the Covered Person may be offered information about obtaining transplant services at a Participating Transplant Center. The term "Participating Transplant Center" means a licensed health care facility which has entered into a participation agreement with the Plan for certain fee arrangements to provide health services to Covered Persons in the Plan. The Participating Transplant Center's goal is to perform necessary transplants in the most appropriate setting for the procedure with consideration for and enhancement of the quality of patient care.

      There is no obligation for the patient to use a Participating Transplant Center. However, benefits for the transplant and its related expenses may vary depending on whether services are provided in or out of the Participating Transplant Center. The Covered Person is free to decide whether or not to receive treatment, services or supplies provided by a Participating Transplant Center without regard to any benefits under this Plan.

    - **Covered Transplant Expenses**
      The term "Covered Expenses" with respect to transplants includes the Usual, Customary and Reasonable expenses for services and supplies which are covered under this Plan (or which are specifically identified as covered only under this provision) and which are Medically Necessary and appropriate to the transplant:

      a. The type of transplant must not be experimental or investigative, based on the criteria stated in the definition of "Experimental Treatment." The type of transplants that meet our criteria for coverage are:

         - Heart;
         - Lung;
         - Heart/lung;
         - Liver;
         - Kidney;
         - Pancreas;
         - Kidney/pancreas; and
         - Certain autologous and allogeneic bone marrow transplants, including hematopoietic stem cell harvesting and infusion, whether harvested from bone marrow, peripheral blood or any other source.

      b. Charges Incurred in the evaluation, screening and candidacy determination process.

      c. Charges Incurred for organ transplantation

d. Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits, as follows:

    i. Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ.

    ii. Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow-up care.

    iii. If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogeneic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of re-infusion.

    iv. Charges Incurred for follow-up care, including immunosuppressant therapy.

    v. Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual. In addition, all covered lodging expenses are limited to a maximum per night as shown in the Schedule of Benefits. All reasonable and necessary transportation, lodging and meal expenses Incurred in connection with one procedure or treatment type will be limited to the Per Occurrence Maximum for a Transplant Benefit Period, as shown in the Schedule of Benefits.

- **Transplant Benefit Period**
  Covered transplant-related travel and lodging expenses will accumulate during a Transplant Benefit Period, and will be charged toward the transplant Per Occurrence Maximums shown in the Schedule of Benefits. The term "Transplant Benefit Period" means the period that begins on the date of the initial evaluation and ends on the date that is twelve consecutive months following the date of the transplant. If the transplant is a bone marrow transplant, the date the marrow is re-infused is considered the date of the transplant.

- **Donor Expenses**
  Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. No coverage is provided for donor expenses when the transplant recipient is not a Covered Person under this Plan.

43. **Outpatient Dialysis Treatment**
This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Covered Persons and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

- The Dialysis Program has been established for the following reasons:

    – the concentration of dialysis providers in the market in which Covered Persons reside may allow such providers to exercise control over prices for dialysis-related products and services,

    – the potential for discrimination by dialysis providers against the Plan because it is a non-federal governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Covered Persons,

- evidence of (i) significant inflation of the prices charged to Covered Persons by dialysis providers, (ii) the use of revenues from claims paid on behalf of Covered Persons to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and

- the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Covered Persons, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Covered Persons' interests, such as subsidies for other plans and discriminatory profit-taking.

- The components of the Dialysis Program are as follows:

  - Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Covered Persons for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

  - Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after December 1, 2013, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Covered Person.

  - Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan shall consider factors including:

    1. Market concentration: The Plan shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

    2. Discrimination in charges: The Plan shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

  - In the event that the Plan's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Covered Person, to the following payment limitations, under the following conditions:

    1. Where the Plan deems it appropriate in order to minimize disruption and administrative burdens for the Covered Person, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

2. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

3. Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

4. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

5. Additional Information related to Value of Dialysis-Related Services and Supplies. The Covered Person, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan based upon credible information from identified sources. The Plan may, but is not required to, review additional information from third-party sources in making this determination.

6. All charges must be billed by a provider in accordance with generally accepted industry standards.

– Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Covered Person is available, the Plan may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

– Discretion. The Plan shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

A provider that accepts the payment from the Plan will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Covered Person and (ii) it shall not "balance bill" a Covered Person for any amount billed but not paid by the Plan.

GENERAL EXCLUSIONS AND LIMITATIONS

This section applies to all benefits provided under any section of this Plan. No benefits are available for the following:

1. Charges in connection with abortion, unless life-threatening to the mother or the result of incest or rape.

2. Charges Incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country; charges for services or supplies rendered or furnished to a Covered Person while he or she is in the active military service of any country. This exclusion does not apply to any Covered Person who is not a member of the armed forces.

3. For unbundled charges, to the extent multiple fees are billed which should have been included in a global fee or surgical suite rate. For fees which are upcoded or exploded, to the extent higher payment is requested than the procedures performed justify. For other billing activity outside the standard of medical or traditional billing practice.

4. Charges for Cosmetic Procedures (including liposuction) and services or supplies for cosmetic purposes, except for the correction of defects incurred through traumatic injuries, services rendered to a Newborn that are necessary for treatment, or correction of a congenital defect, as the result of an Illness or the surgical procedure to treat an Illness or Injury, or as otherwise specifically included.

5. Charges for counseling in connection with marriage, family, child, career, social adjustment, pastoral or financial issues, except as specifically included.

6. Charges Incurred in connection with Custodial Care.

7. Anesthesia and facility charges associated with dental services and charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or a molar process and any other dental, orthodontic or oral surgical charges, except as specifically included.

8. Charges for education or training. This exclusion does not apply to an outpatient self-management training or education program for diabetes, as specifically included for coverage.

9. Charges arising out of or in the course of any employment or occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or occupational disease law, or any such similar law.

10. Charges in excess of the Usual, Customary and Reasonable allowance for the services or supplies, or in excess of any maximum or limits considered for benefits under the Plan.

11. Charges for exercise programs for treatment of any condition, except Physician-supervised, Medically Necessary cardiac rehabilitation or Occupational Therapy or Physical Therapy which is specifically included.

12. Charges for Experimental Treatment.

13. Charges for routine foot care.

14. Charges for care, treatment or supplies furnished by a program or agency funded by any government, except for Medicaid or when otherwise prohibited by law.

15. Charges for care and treatment for hair loss, including wigs, hair transplants and any drug that promises hair growth, unless prescribed by a Physician.

16. Charges for Hospital admissions when such Confinement is for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not connected with the

actual Illness or Injury, for treatment of a non-covered illness or injury, or for covered treatment that could have been performed on an Outpatient basis without adversely affecting the patient's physical condition or the quality of medical care rendered.

17. Charges for professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and who is paid by that Hospital or Facility for their services.

18. Charges related to, resulting from or occurring during the commission of a felony by the Covered Person, including without limitation, engaging in an illegal occupation or act, but excluding minor traffic violations.

19. Charges for services rendered by a member of the Covered Person's immediate family or by a person who normally resides in the Covered Person's household. For purposes of this exclusion, "immediate family" means a spouse, Child, brother, sister, brother-in-law, sister-in-law, parent, parents-in-law or grandparent.

20. Charges Incurred in connection with surrogacy, in-vitro fertilization, embryo transfer procedure, G.I.F.T. (Gamete Intrafallopian Transfer), artificial insemination, or any type of artificial impregnation procedure, whether or not such procedure is successful.

21. Charges for jaw augmentation or reduction (orthognathic surgery), regardless of the origin of the condition that makes the procedure necessary.

22. Charges to the extent they exceed the Medicare limiting charge, for Covered Persons for whom this Plan pays its benefits secondary to Medicare.

23. Inpatient and outpatient treatment of Mental or Nervous Conditions.

24. Charges Incurred for education or training other than as specifically provided in the Plan, hypnosis, standby Physician services, completion of forms, mailing and shipping expenses, missed appointments, telephone calls, or chelation therapy (except to treat heavy metal poisoning.

25. Charges for services or supplies which are incurred at a time when no coverage is in force for that person.

26. Charges for which the Covered Person is not legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

27. Charges for services or supplies which are not Medically Necessary for the diagnosis or treatment of an Illness or Injury.

28. Charges for services or supplies not recommended by a qualified Physician, nutritional supplements and drugs, medicines or medical supplies that do not require a written prescription to purchase, services not performed according to accepted standards of medical practice, or services performed outside the scope of the provider's license.

29. Charges for Orthotic Appliances.

30. Charges for services and supplies that are specifically limited or excluded in other parts of this Plan or not specified as covered under the Plan.

31. Charges for homeopathy; primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; carbon dioxide therapy, and charges Incurred for holistic, environmental or ecologic health care, including drugs and ecologicals.

32. Charges Incurred outside the United States if the Covered Person traveled to such a location for the primary purpose of obtaining medical services, drugs or supplies.

33. Charges for services or supplies for personal comfort (for example, the difference between a private room charge and the Semi-Private allowance), beautification items and television or telephone use.

34. Charges for replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

35. For charges which cannot be evaluated for possible coverage under the Plan because the Employee or Covered Person refuses to comply with release of or requests for information.

36. Charges for biofeedback.

37. Charges Incurred in connection with the reversal of surgical sterilizations, sexual dysfunctions or inadequacies, penile prosthetic implants, impotency drugs, or gender reassignment.

38. Charges in connection with Speech Therapy, except as specifically included.

39. Charges for or in connection with any Injury or Sickness subject to the "Third Party Recovery, Subrogation and Reimbursement" provision of this Plan, unless and until the requirements of that provision have been met to the satisfaction of the Plan in its sole discretion.

40. Inpatient and outpatient treatment of Substance Abuse.

41. Charges for transplants, except as provided in the transplant benefit provision. Non- human organs, Experimental or Investigational transplant services and supplies, and any transplant expenses which are eligible to be paid under any private or public research fund, government program or other funding program, are not covered.

42. Charges Incurred for travel, except as specifically included.

43. Charges Incurred in connection with eye refractions; the purchase or fitting of eyeglasses or contact lenses, except the initial purchase of eyeglasses or contact lenses following cataract surgery; radial keratotomy or other refractive surgery for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error.

44. Charges for care and treatment of obesity, including morbid obesity, weight loss or dietary control whether or not it is, in any case, part of the treatment plan for another Illness.

PRESCRIPTION DRUG BENEFITS

"Participating Pharmacies" are pharmacies that have contracted with the Plan to charge reduced fees for covered drugs. Covered Persons will be issued an identification card to use at the Participating Pharmacy at time of purchase. A purchase directly from a Participating Pharmacy using the Plan identification card is called the "Retail Network Pharmacy Option". Covered Persons may not use a Plan identification card to purchase drugs at any time coverage is not in effect, and will be held fully responsible for the consequences of any such use.

An option is also available to order maintenance drugs through the mail (the "Mail Order Option"). "Maintenance drugs" are medications prescribed for chronic, long-term Illnesses or Injuries which are required on a regular, recurring basis. Examples of chronic conditions that may require maintenance drugs are: asthma, heart disease, high blood pressure, high cholesterol, epilepsy and diabetes.

If you fail to show your Plan identification card at the pharmacy, or if you use a non-Participating Pharmacy, you must pay for the cost of the drug and file your claim for reimbursement directly with CVS/Caremark at the address shown above. Your reimbursement will be determined based upon the amount that the Plan would have paid if you had used a Participating Pharmacy.

The copayment is applied as shown on the Schedule of Benefits. The copayment amount is not counted toward any Out-Of-Pocket Maximum Expense under the Plan.

Covered Expenses

The following are covered under the Plan:

1. All drugs prescribed by a Physician that require a prescription (including contraceptives) either by federal or state law, except the drugs excluded below;

2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. Compound medications in excess of $500 require prior authorization and are limited to one fill per 25 days; and

3. Insulin, insulin syringes and needles, and insulin-related chemical strips, when prescribed by a Physician for the treatment of diabetes.

Limitations

The benefits set forth in this section will be limited to:

1. The cost of a generic drug if a generic drug is available. However, the brand name drug will be considered a covered expense if a generic drug is not available. If the Covered Person requests a brand name drug when a generic drug is available, even if the Physician has written DAW on the prescription, then, in addition to the generic drug copay, the Covered Person must pay the difference between the cost of the generic drug and the brand name drug.

2. Tretinoin agents used in the treatment of acne and/or for cosmetic purposes (ex. Retin-A) are covered through age 25 only.

3. Refills only up to the number of times specified by a Physician;

4. Refills up to one year from the date of order by a Physician;

5. With respect to the Retail Network Pharmacy Option and any Specialty medication, any one prescription is limited to a 30-day supply; and

6. With respect to the Mail Order Option, any one prescription is limited to a 90-day supply.

Exclusions
The following exclusions and limitations are in addition to those set forth in the section entitled “General Exclusions and Limitations.” No benefits will be paid for the following:

1. Devices or appliances, support garments and other non-medicinal substances, regardless of their intended use, except as specifically included.

2. For the Retail Network Pharmacy Option - More than a 30-day supply in any one prescription or refill. Through the Mail Order Option - more than a 90-day supply (or the amount otherwise limited by state law), when dispensed in any one prescription or refill. Through either method - Any prescription refill in excess of the number specified by the Physician or allowed by law, or any refill dispensed after one year from the order of the Physician or the maximum time allowed by law if less than one year.

3. Drugs labeled “Caution - limited by federal law to Investigational use,” or Experimental Treatment drugs, even though a charge is made to the individual.

4. Prescriptions which an eligible person is entitled to receive without charge from any governmental program.

5. Charges for the administration or injection of any medication, other than vaccines.

6. Medication which is taken or administered, in whole or part, while the person is confined in a Hospital or other health care facility

7. Prescriptions which an eligible person is entitled to receive without charge under any workers’ compensation or similar law.

8. Anorexiants (weight-loss drugs) and anti-obesity drugs; fertility drugs; erectile dysfunction drugs; nutritional supplements; Rogaine; and smoking deterrent products.

9. Replacement of lost or stolen medication.

10. Over-the-counter drugs, except for insulin, even if prescribed.

Prescription Drug Coordination of Benefits
You may also be covered under another prescription benefit program. This Plan includes a “coordination of benefits” feature to handle such situations. If the other program pays benefits first, you can submit your pharmacy receipts to CVSCaremark for reimbursement. The amount of your reimbursement will be the amount you paid to the pharmacy for your prescription, less this Plan’s applicable copayment amount. Please refer to the Schedule of Benefits for a listing of copayment amounts.

Specialty Medications
Specialty medications are complex, high cost medications. To help facilitate the safe and effective use of these drugs, the Plan requires prior authorization and limits the quantity purchased at one time to a 30-day supply. For a list of specialty medications, go to: www.cvscaremarspecialtyrx.com .

Specialty Step-Therapy
The plan requires participation in a step therapy program for specialty prescriptions. If you are filling a specialty prescription for the first time, you must try a preferred medication before trying other alternatives. If you choose a non-preferred specialty drug without first trying the preferred medication, you may be responsible for the full cost of the non-preferred brand medication.

DENTAL BENEFITS

In accordance with the Schedule of Benefits, the Plan will pay for the following services:

Type I: Diagnostic and Preventive Services

1. Routine oral examinations, limited to two examinations in any 12-month period, and problem-focused examinations limited to two examinations in any 12-month period.

2. Diagnostic services, including diagnostic x-rays, as follows:

    a. Full mouth series including bitewings, if needed, and panoramic film;

    b. Bitewing films; and

    c. Vertical bitewing x-rays.

3. Topical fluoride application for Covered Persons under age 20, limited to two treatments in any 12-month period.

4. Prophylaxis, limited to two in any 12-month period.

5. Sealants for Covered Persons under age 14.

6. Space maintainers when needed to preserve space resulting from the premature loss of deciduous teeth, including all adjustments in the first six months after installation.

Type II: Restorative Services

1. Emergency palliative treatment.

2. Diagnostic x-rays, including:

    a. Intraoral periapical or occlusal x-rays-single films; and

    b. Extraoral superior or inferior maxillary film.

3. Extractions.

4. Amalgam, silicate, acrylic, synthetic, porcelain and composite filling restoration to restore diseased or accidentally broken teeth

5. Oral Surgery performed on the teeth or gums.

6. Transplantation of tooth or tooth bud.

7. General anesthetics and IV sedation administered in the Dentist's office in connection with covered oral or dental surgery.

8. Treatment of periodontal and other diseases of the gums and tissue of the mouth.

9. Injection of antibiotic drugs by an attending Dentist.

10. Endodontics, including root canal therapy.

11. Crowns (when tooth cannot be restored with a filling material):

a. Prefabricated stainless steel; and

b. Prefabricated resin crown (excluding temporary crowns).

12. Repair or re-cementing of crowns, inlays, and bridgework, and repair of dentures.

Type III: Reconstructive Services

1. Inlays, onlays, gold fillings and crown restorations (including post and core) to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive cavities or fractures, cannot be restored by amalgam, silicate, acrylic, synthetic, porcelain or composite filling restoration.

2. Labial veneers, resin and porcelain laminate.

3. Initial installation of fixed bridgework, including inlays and crowns as abutments.

4. Initial installation of partial or full removable dentures, including precision attachments and any adjustments during the six-month period following installation.

5. Replacement of an existing partial or full removable denture, new bridgework or the addition of teeth to an existing partial or full removable denture or bridgework, except that only replacements and additions that meet the "Prosthesis Replacement Rule" below will be covered.

6. Relining or rebasing of dentures more than 6 months after initial placement or replacement of dentures.

7. Occlusal guard (for bruxism only) limited to one in any Calendar Year.

Prosthesis Replacement Rule
The "Prosthesis Replacement Rule" requires that replacements or additions to existing dentures or bridgework will be covered only if satisfactory evidence is furnished that one of the following applies:

1. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture was installed;

2. The existing denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement; or

3. The existing denture is an immediate temporary denture that cannot be made permanent and replacement by a permanent denture is required and takes place within twelve months from the date of initial installation of the immediate temporary denture.

Dental Treatment Plan
If a Covered Person's proposed course of treatment reasonably can be expected to involve dental charges of $450 or more, a description of the procedures to be performed and an estimate of the charges may be filed with the Plan or Claims Administrator prior to the commencement of the course of treatment. However, approval is not required prior to treatment. Any pre-determination of dental benefits is provided only as a convenience to the Covered Person.

If requested, the Plan or Claims Administrator will notify the Covered Person, and the Dentist or Physician, of the pre-determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre-determination is not a guarantee of payment or approval of a benefit.** After treatment is received, a claim must be filed as a post-service claim, which will be subject to all applicable Plan provisions.

Dental Exclusions and Limitations
The following exclusions and limitations are in addition to those set forth in the section entitled "General

Exclusions and Limitations." No benefits will be paid for the following:

1. Charges for Cosmetic Procedures, including, but not limited to, personalization or characterization of complete or partial denture restoration.

2. Charges for oral hygiene instructions, plaque control or dietary planning.

3. Charges for replacement of dentures and removable or fixed prosthesis due to theft, misplacement or loss.

4. Charges for appliances or restorations used solely to increase vertical dimensions, restore occlusion (orthodontia), to correct temporomandibular joint dysfunction (TMJ) or pain syndrome, or to correct attrition, abrasion or erosion.

5. Charges for space maintainers, except as specifically included.

6. Charges for general anesthesia and intravenous sedation in connection with a non-covered service.

7. Charges for services not provided by a Physician or Dentist, except cleaning and scaling of teeth and topical application of fluoride may be performed by a Licensed Dental Hygienist under the supervision of a Physician or Dentist.

8. Charges for any services or supplies which are eligible for coverage under any other part of the Plan.

9. Charges for fixed bridgework, or a crown or a gold restoration if involving a replacement or modification of a denture, bridgework, crown or gold restoration which was installed during the five years immediately preceding such replacement or modification.

10. Charges for any portion of a dental procedure Incurred before the effective date or after the termination of the individual's coverage.

    An expense will be considered Incurred as defined in the section, "Definitions," or as follows:

    a. For an appliance or modification of an appliance, the date the impression was taken;

    b. For crowns, bridge work or gold restorations, the date the tooth was seated; and

    c. For root canal therapy, the date the pulp chamber was opened.

    If the procedure is completed within 90 days after termination of coverage and the individual is not otherwise entitled to payment under any other like dental coverage of any type or source, the charge will be considered as Incurred prior to the date of termination.

11. Charges for temporary restorations.

12. Dental care that does not have ADA endorsement.

13. Customized dental procedures.

14. Charges for facility and anesthesiologist are specifically excluded, unless performed in a Dentist's office.

The Covered Person is responsible for payment of any charges that exceed any stated benefit limits or maximums and for any services and supplies not covered under this Plan. Charges for dental services in excess of the benefits available under this section are not covered under other sections of this Plan and do not accumulate toward the Out-of-Pocket Maximum Expense.

VISION BENEFITS

The Plan provides benefits for vision services. See the Schedule of Benefits for information about the Plan's benefit frequency. The vision benefits are administered by Vision Service Plan (VSP).

Covered Services
The vision plan covers charges for eye care when provided or prescribed by an ophthalmologist or optometrist. Benefits will be limited to the Member Doctor or Non-Member Provider Benefit allowances.

You and your Dependents may use the services of a Vision Service Plan (VSP) member doctor or any other licensed ophthalmologist or optometrist or dispensing optician.

Exam
This Plan covers one complete examination per person every 12 consecutive months from your last date of service.

Conventional Lenses
Prescription lenses will be covered once during any 24 consecutive months from your last date of service, if a visual analysis indicates new lenses are necessary.

Frames
A new frame will be covered whenever necessary, but not more than once during any 24 consecutive months from your last date of service.

Contact Lenses – Elective
If contact lenses are elected instead of eyeglasses, the Plan will provide a benefit. This benefit will use up your lenses and frame benefit. For example, you will not be eligible again for lenses or a frame until 24 months after the date you purchased your contacts.

Contact Lenses – Medically Necessary
Medically necessary contact lenses may be prescribed by a VSP doctor for certain conditions. A VSP doctor must receive prior approval from VSP for medically necessary contact lenses. Upon approval from VSP, the medically necessary contact lenses will be paid according to the Schedule of Benefits. When prescribed by a non-member doctor, the non-member doctor must get prior approval from VSP for this benefit to be paid.

A patient who has received either Elective or Medically Necessary contact lenses would again be eligible for vision benefits as follows:

- Examination and conventional lenses, after 12 months;
- Frames, after 24 months; and
- Contact lens replacement, after 24 months if a change in prescription so indicates.

Services Not Paid Under Vision Benefits
- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an Experimental Nature;
- Costs for services and/or materials above Plan Benefit allowances;
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

Benefit Limitations
This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).

PLAN ADMINISTRATION

The Plan is administered by the Board of Trustees. The Board of Trustees has retained the services of Welfare & Pension Administration Service, Inc. (WPAS) to provide certain claims processing and other technical services. Prescription benefits are administered by CVS Caremark. Vision claims are processed by Vision Service Plans (VSP).

The Board of Trustees shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Board of Trustees shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies and care are Experimental Treatments), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Board of Trustees as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Board of Trustees decides, in its discretion, that the Covered Person is entitled to them.

The Plan has the discretionary authority to decide whether a charge is Usual and Reasonable or Usual Customary and Reasonable. Benefits under this Plan shall be paid only if the Board of Trustees decides in its sole discretion that a Covered Person is entitled to them.

Amending and Terminating the Plan

Except as cited under the Continuation Coverage section, this Plan does not confer rights beyond the date that coverage is terminated. For this reason, no rights from this Plan can be considered "vested" rights. You are not eligible for benefits or payments from this Plan for any services, treatment, medical attention, or care rendered after the date your coverage terminates. The Board of Trustees retains the right to change the benefits provided under the Plan in its discretion as the Plan fiduciary.

In the event of plan termination, the allocation of plan assets shall be accomplished according to the provisions contained in the Trust agreement.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

You will receive Plan identification (ID) card, which will contain important information, including claim filing directions and contact information.

At the time you receive treatment, show your ID card to your provider of service. In most cases, your provider will file your claim for you. You may file medical and dental claims yourself by submitting the required information to:

APEA-AFT Health Benefits Trust
PO Box 34840
Seattle, WA 98124-1840

A Claim means a request for a Plan benefit, made by a Covered Person (Plan Participant or by an authorized representative of the Plan Participant) that complies with the Plan's reasonable procedures for filing benefit claims. A Claim does not include an inquiry on a Covered Person's eligibility for benefits, or a request by a Covered Person or his/her physician for preauthorization of benefits for medical treatment.
A Covered Person may appoint an authorized representative to act on his/her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply because of an assignment of benefits. Contact the Plan Administrator for information on the Plan's procedures for appointing an authorized representative.

Claims that are properly filed with the Plan Administrator will be processed in accordance with the following guidelines:

- Pre-Service Non-Urgent Health Claims. A pre-service health claim is a properly filed claim for medical or dental benefits that must be preauthorized to receive full benefits from the Plan. Pre-service claims are only claims to the extent that preauthorized services are reviewed and determined to be Medically Necessary for the appropriate level of care requested. Pre-service determinations do not address the Covered Person's eligibility or Plan coverage for specific services or treatment. **Failing to obtain preauthorization for a pre-service claim may result in reduced or denied benefits.** Pre-service claims include, but are not limited to non-emergency admission to a Hospital, or a Skilled Nursing Facility, Home Health Care or Hospice Care. A pre-service claim will generally be processed within 15 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies the Covered Person within the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary due to the claimant's failure to submit the information necessary to process the claim, the notification of the extension will be provided to the Covered Person as soon as possible, but not later than 5 days after the receipt of the claim. The notice will describe the specific necessary information needed to process the claim, and the Covered Person will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the Covered Person until the date on which the Covered Person responds to the request for additional information within the extension period described in the notice of not less than 45 days from the notice.

  If services that require preauthorization have been provided and the only issue is what payment, if any, will be made, the claim will be processed as a post-service claim.

- Post-Service Health Claims. A post-service health claim is any properly filed claim for medical, dental, vision, audio, or Prescription Drug benefits that is not a pre-service claim and does not involve urgent care, where the treatment or services have already been provided. A post-service claim will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies the Covered Person within the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is

necessary due to the Covered Person's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the Covered Person will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the Covered Person responds to the request for additional information within the extension period described in the notice of not less than 45 days from the notice.

- Urgent Care Health Claims. Urgent care health claims are pre-service claims with respect to which the normal time frames for review of a claim could seriously jeopardize the life or health of the claimant, or expose the Covered Person to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed, orally or in writing, by the Covered Person or by the health care provider with knowledge of the Covered Person's medical condition. A decision on an urgent care will generally be made within 72 hours after receipt of a claim that is complete when submitted. A Covered Person will be notified within 72 hours if additional information is required to process the claim, and will be provided at least 48 hours to submit the additional information. If additional information is required to process the claim, a determination will be made within 48 hours of the earlier of the Plan's receipt of the requested information, or the end of the period afforded the Claimant to provide the additional information. A determination involving urgent care may be provided orally within the time frames in this section, with a written notification furnished not later than three days after the oral notification.

  It is important to remember that, if a Covered Person needs emergency medical care for a condition which could seriously jeopardize his/her life, there is no need to contact the Plan for prior approval. The Covered Person should obtain such care without delay. Further, if the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no Pre-Service Claim. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment and files the claim as a Post-Service Claim.

- Concurrent Care Claims. Concurrent care claims are pre-service claims involving an ongoing course of treatment to be provided over a period of time or for a number of treatments. Except in the case of urgent care, a claim to extend a course of treatment beyond the period of time or number of treatments previously approved, will be treated as a new claim and processed within the timeframes appropriate to the type of claim. A claim to extend a course of treatment that involves urgent care will be processed within 72 hours after receipt of the claim, provided the claim is made to the Plan at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the claim is not made at least 72 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care. If the Plan reduces or terminates certification for a course of treatment before the end of the previously approved period or number of treatments, the Plan will notify the Covered Person in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review before the benefit is reduced or terminated.

Most claims under the Plan will be "Post Service Claims." As noted above, a "Post Service Claim" is a claim for a benefit under the Plan after the services have been rendered. Post Service Claims must include the following information in order to be considered filed with the Plan:

A Form HCFA or Form UB92 completed by the provider of service, including:

1. The date of service;

2. The name, address, telephone number and tax identification number of the provider of the services or supplies;

3. The place where the services were rendered;

4. The diagnosis and procedure codes;

5. The amount of charges (including PPO network repricing information);

6. The name of the Plan;

7. The name of the covered Employee; and

8. The name of the patient.

When Health Claims Must Be Filed
Health claims must be filed with the Claims Administrator within 365 days of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

Claims filed later than that date shall be denied regardless of the reason for the delay in filing the claim timely.

Notification of an Adverse Benefit Determination
The Plan shall provide a Covered Person with a notice, either in writing or electronically, containing the following information:

1. A reference to the specific portion(s) of the summary plan description upon which a denial is based;

2. Specific reason(s) for a denial;

3. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;

4. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits;

5. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

6. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person, free of charge, upon request); and

7. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental Treatment), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request

Remedies Available Should A Claim Be Denied
A Covered Person may appeal an adverse benefit determination. The Plan offers a two-level internal review procedure to provide a Covered Person with a full and fair review of an adverse benefit determination. If a Covered Person completes the two levels of internal review and is dissatisfied with the determination on internal review, the Covered Person may request an External Review in accordance with the procedures that follow under the title External Review Procedure.

In cases where coverage has been rescinded or a claim for benefits is denied, in whole or in part, and you believe the claim has been wrongfully denied, you may appeal the denial and review pertinent documents. The claims procedures of this Plan provide you with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. 180 days following the notification of an adverse benefit determination within which to appeal the determination;

2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. A review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

4. A review that takes into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

5. In deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and expertise in the field of medicine involved in the medical judgment, who 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;

6. The identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

7. The Covered Person, upon request and free of charge, shall be given reasonable access to, and copies of, all documents, records, and other information relevant to their claim for benefits in possession of the Health Trust Administrator; any internal rule, guidelines, protocol, or other similar criterion relied upon in making the adverse benefit determination; and any explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances.

Exhaustion of Remedies
When a claim has been denied or partially denied, the Covered Person may seek an appeal under these Internal Review procedures. The Covered Person must follow steps in this appeal process in the order and time designated or the Covered Person will lose the right to further review of the claim denial.

The first level of review will be performed by the Plan Administrator on the Plan's behalf. The appeal must be filed in writing within 180 days following the date on the written notice of an adverse benefit determination. To file an appeal in writing, the appeal must be addressed as follows:

APEA-AFT Health & Welfare Trust
Welfare and Pension Administration Service, Inc.
c/o Appeals
P.O. Box 43203
Seattle, WA 98124-1203

It shall be the Covered Person's responsibility to submit proof that the claim for benefits is covered and payable under the Plan provisions. Appeals must include:

1. The name of the Covered Person;

2. The Covered Person's alternative Plan identification number or social security number;

3. All facts or theories supporting the claim for benefits;
4. A statement in clear and concise terms of the reason or reasons based on the Plan provisions for the disagreement with the handling of the claim; and

5. Any material or information that the Covered Person has which indicates that he/she is entitled to benefits under the terms of the Plan.

Timing and Notification of Benefit Determination on Appeal
The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following time frames:

- Urgent Care Claims – within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after receipt of the claim.

- Pre-Service Non-Urgent Care Claims – within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

- Concurrent Claims – the response will be made in the appropriate time period based on the type of claim (Pre-service Non-Urgent or Post Service).

- Post-Service Claims – within a reasonable period of time, but not later than 30 days after receipt of the appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time the Level 1 Internal Review is filed, as determined by the post-mark (or if hand delivered or delivered electronically, the date of receipt by the Plan Administrator), regardless of whether all information necessary to make a determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination
If a claim is denied or partially denied, the Covered Person will be notified in writing. For questions about the denial of benefits, the Covered Person should contact the Plan Administrator at the address and telephone number shown on the Notice of Determination.

Level 1- Appeal Review
If the Covered Person does not agree with the determination, the Covered Person can submit a written appeal to the Plan Administrator. The Plan Administrator will provide the first level review of the appeal and notify the Covered Person, in writing or electronically, notice of the determination.

If the denial of benefits for the claim is upheld, the notice to the claimant will give the following:

1. Information to identify the claim, including, the date of service, the health care provider, the claim amount (if applicable).

2. Specific reasons for the denial;

3. Specific reference to pertinent Plan provision(s) on which the denial is based;

4. A description of any additional material or information necessary for the Covered Person to perfect the claim and an explanation of why such material or information is necessary;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the Covered Person upon request;

6. If the denial is based on medical necessity, or experimental or investigational treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;

7. A statement that the Covered Person is entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

8. A description of the Plan's internal review and External Review Procedure and the applicable time limits.

9. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice, will only be released subject to state or federal regulations; applicable state and federal regulations must be followed.

10. The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established by the Public Health Service Act Section 2793.

Level 2 – Internal Review

The Level 2 Internal Review will be done by the Board of Trustees, as the Plan Fiduciary. The Covered Person shall have the right to request a hearing before the Board of Trustees, by submitting the request in writing to the Plan Administrator at the address noted on the notice of the Level 1 Review determination, within sixty (60) calendar days of the date of the notice. The Covered Person may present his/her testimony and argument to the Trustees. The Covered Person may be represented by an attorney or other authorized representative. The Board of Trustees may afford the Covered Person or his/her authorized representative the opportunity to appear in person or telephonically at the hearing.

The Board of Trustees will review the information initially received and any additional information provided by the Covered Person, regardless of whether such information was submitted by the Covered Person or considered in the Level 1 Internal Review. The Board of Trustees will not afford deference to the initial adverse benefit determination. When deciding an appeal that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination will be released subject to state or federal regulations; applicable state and federal regulations must be followed. Any health care professional engaged for the purpose of a consultation on a claim will not be an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Trustees will review a properly filed appeal of a post-service claim at the next regularly scheduled Board of Trustees meeting following receipt of the properly submitted second level appeal, provided the second level appeal is received at least twenty (20) calendar days prior to such regularly scheduled Board of Trustees meeting. If the second level appeal is not received within 20 calendar days of the next regularly scheduled Board of Trustees meeting, the appeal will be set for hearing at the next Trustee meeting.
If the claim involves the reduction or termination of a previously approved claim for Concurrent Care or Non-Urgent Pre-Service care, the Trustees will review the second level appeal within 15 days of receipt of the properly filed second level appeal regardless of the date of the next regularly scheduled Board of Trustees meeting. The Trustees will review a properly filed second level appeal of an Urgent Care claim within 72 hours after receipt of the appeal regardless of the date of the next regularly scheduled Board of Trustees meeting. In such cases, such appeal hearing may be conducted via teleconference or email poll.

All necessary information on a claim for Concurrent Care, Non-Urgent Pre-Service care, or Urgent Care may be transmitted between the Plan and the claimant by telephone, facsimile, or other available expeditious method. The Trustees may delegate the decision on an expedited appeal to a Committee of not less than two Trustees or to the Plan Administrator upon prior approval of a quorum of the Board of Trustees. Decisions on Concurrent Care, Non-Urgent Pre-Service care, or Urgent Care second level appeals will be provided to the appellant telephonically by the Administrator following the meeting, with a written decision to follow as soon as practical, but not more than five (5) days following the decision.

The Board of Trustees will issue a decision on a Post-Service Level 2 Internal Review as soon as practical but not more than thirty (30) business days after the Level 2 Internal Review hearing.

External Review Procedure

The Plan has an external review procedure for determinations that involve medical judgment or rescission of coverage that provides for a review conducted by a qualified Independent Review Organization (IRO).

The Covered Person cannot request an External Review (as described more fully below) unless the appeal was filed timely and Levels 1 and 2 of the Internal Review process were completed. The Covered Person may request a review by an IRO within 4 months after the date of the notice of the Plan's adverse decision regarding the Level 2 Internal Review. If there is no corresponding day 4 months after the date of the notice on the Level 2 Internal Review appeal determination notice, then the request must be filed by the 1st day of the fifth month following the date of the notice. As with the original appeal, the Covered Person's request for external review must be submitted in writing to the Plan Administrator and include all of the items set forth in 1-5 of the section above entitled Level 1 – Internal Review. The Plan is entitled to charge a fee of $25 to initiate an External Review, which the Covered Person must pay to the Plan when submitting the Request for External Review Form to initiate the process.

For an adverse benefit determination to be eligible for external review, the Covered Person must complete the required forms to process an External Review. The Covered Person may obtain the appropriate forms and information on the filing process by contacting the Plan Administrator.

The external review process is only for appeals involving 1) medical judgment, including but not limited to determinations that involve medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, experimental or investigational treatments; and, 2) Rescissions of coverage (whether or not the rescission has any effect on any particular benefit at that time). Medical judgment excludes determinations that only involve contractual or legal interpretation or those related to a participant's eligibility for benefits under the terms of the Plan, without any use of medical judgment. You cannot request an external review unless your appeal was filed timely and Levels 1 and 2 of the internal process have been completed.

An appeal of an adverse benefit determination that does **not** involve medical judgment or rescission of coverage may not be appealed to IRO. Rather, a Claimant has to option of filing a lawsuit within one (1) year of the final determination after exhausting Levels 1 and 2 of the internal appeal process.

Preliminary Review for External Review Request
Within 6 business days following the date of receipt of the Covered Person's external review request, the Plan Administrator will send the Covered Person a written notice stating whether the request is eligible for external review and if additional information is necessary to process the request. If the request is determined to be ineligible, the notice will include the reasons for ineligibility and provide contact information for the appropriate State or federal oversight agency. If additional information is required to process the external review request, the notice will describe the information needed and you may submit the additional information within the 4 month filing period or within 48 hours of receipt of the notification, whichever is later.

Timing of Notice from the IRO
After receiving your request for an external review from the Plan Administrator, the IRO will notify you in writing of your rights to submit additional information to the IRO and the applicable time period and procedure for submitting such information.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain the reasons and rationale for the decision, including any applicable evidence-based standards used, and references to the evidence or documentation considered in reaching the decision.

Decision of IRO Final
The decision of the IRO is binding upon you and the Plan, except to the extent other remedies may be available under applicable law. Before filing a lawsuit against the Plan, you must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative,

the Covered Person must complete a form which can be obtained from the Plan or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan, in writing, to the contrary.

OTHER PLAN PROVISIONS

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose condition, Illness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, Illness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits
All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Illness or Injury, or whose covered Dependent's Illness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, the Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

Assignments
Benefits for expenses covered under this Plan may be assigned by a Covered Person to the provider; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

Hospitals must agree to submit itemized bills, chart notes and other medical records that are necessary and appropriate for any audit required at the discretion of Plan, and must agree to cooperate with the Plan's designated auditor free of charge in order for the Plan to honor any assignment of benefits by the Covered Person to the Hospital. Details are contained in the section, "Right to Audit".

Right to Audit
At the sole discretion of the Plan, Hospital bills will be professionally audited for compliance with nationally-accepted billing and coding standards. Coverage for any undocumented or unbundled codes for services and supplies will be denied. Otherwise eligible charges by the Hospital must satisfy the Allowable Charge definition in order to be Covered Expenses.

In order for the Plan to honor any assignment of benefits by the Covered Person to the Hospital:

1. The Hospital must agree to submit itemized bills, chart notes and other medical records that are necessary and appropriate for such an audit;

2. The Hospital must agree to fully cooperate with the Plan's designated auditor; and

3. The Hospital must comply with the audit and the Plan's designated auditor free of charge.

Covered Person Responsibilities:

1. The Covered Person will be responsible for any amount owed to the Hospital due to its failure to comply with this provision.

2. The Covered Person will be responsible for any amount owed to the Hospital for charges that are found to be in excess of the Allowable Charge. Any such amounts will not be considered Covered Expenses under the Plan.

Each Covered Person has a free choice of any provider, and the Covered Person, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Non-U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non-U.S. Provider;

2. The Covered Person is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;

3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred date;

4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and

5. Claims for benefits must be submitted to the Plan in English.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Covered Person or dependent on whose behalf such payment was made. The Plan may offset the amount against future benefit payments.

A Covered Person, Dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan or its agent. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Medicaid Coverage
A Covered Person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when the Employee or any of his or her Dependents who are covered by the Plan are also covered by one or more Other Plans. When more than one coverage exists, one Plan normally pays its benefits in full and the other Plans pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount that, when added to the benefits payable by the Other Plan(s), will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against the Plan benefit maximums.

"Allowable Expenses" means any Medically Necessary, reasonable and customary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be the benefit.

Please note: This Plan contains an exclusion which provides that no benefits are available for charges Incurred for which the Covered Person is entitled to receive benefits during an extension period of his or her previous health plan. Allowable Expenses will exclude any such charges.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider

It is important that you fulfill any requirements of Other Plan(s) for payment of benefits. If you fail to properly file for, and receive payment by, any Other Plan(s), this Plan will estimate the benefits that would otherwise have been payable and apply that amount, as though actually paid, to the "Payment" calculation explained in this section.

The Claims Administrator may release to and obtain from any other insurer, Other Plan or party, any information that it deems necessary for purposes of this provision. A covered Employee shall cooperate in obtaining such information and shall furnish all information necessary to implement this provision. Failure to do so may result in the denial of benefits under this Plan.

Other Plans

The term "Other Plan," as used in this provision to refer to a plan other than this Plan, means any plan, policy or coverage providing benefits or services for or by reason of health, medical, vision or dental care or treatment. Such plans may include, without limitation:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:
    a. Hospital indemnity benefits; and
    b. Hospital reimbursement-type plans;
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A licensed Health Maintenance Organization (HMO);
5. Any coverage for students that is sponsored by, or provided through a school or other educational institution;

6. Any coverage under a Government program, and any coverage required or provided by any statute;

7. Group automobile insurance;

8. Individual automobile insurance coverage on an automobile leased or owned by the employer;

9. Individual automobile insurance coverage based upon the principles of "No Fault" coverage;

10. Any plans or policies funded in whole or in part by an employer or deductions made by an employer from a person's compensation or retirement benefits;

11. Labor/management trustees, union welfare, employer organization or Employee benefit organization plans;

12. Individual homeowner's insurance coverage;

13. Individual renter's insurance coverage; or

14. Individual boat owner's insurance coverage.

Claim Determination Period
The term "Claim Determination Period" means a Calendar Year, or that portion of a Calendar Year during which the Covered Person for whom a claim is made has been covered under this Plan.

Coordination Procedures
Unless determined to be primary, benefits paid under this Plan will be reduced, so that the sum of benefits paid under this Plan and benefits paid by any Other Plans for Covered Expenses do not exceed Allowable Expenses. A plan which is primary will pay before a plan which is secondary or subsequent.

Payments
This Plan will determine benefits according to the following rules:

1. If a plan contains no provision for Coordination of Benefits or states that its coverage is primary, then it pays before all other plans; or

2. If the plan that covers the claimant directly is through COBRA, and the other plan that covers the claimant, either as a dependent or directly, is through active status, then the active status plan is primary payer. Otherwise, the plan that covers the claimant directly (other than as a dependent) is primary payer. For purposes of this determination rule, "claimant" means the employee (or former employee) or spouse upon whose expenses the claim is based;

3. If the claimant is a Dependent Child, then the plan of the parent whose birthday falls first (omitting year of birth) in the Calendar Year is primary. However, if his or her parents are divorced or separated (whether or not ever legally married) then:

    a. The plan of the parent with custody will be primary, unless a court order or decree specifies the other parent has financial responsibility, in which case that parent's plan would be primary; or

    b. If the parent with custody has remarried, the plan of the parent with custody will be considered primary. The plan of the stepparent that covers the Child as a Dependent will be considered secondary. The plan of the parent without custody will be considered last. or

4. A "no fault" automobile policy not described in sub-paragraph (1) above will be primary; or

5. If the order set out in 1, 2, 3, or 4 above does not apply in a particular case, then the plan that has covered the claimant for the longest period of time will be primary.

The Plan has the right:

1. To obtain or share information with an insurance company or other organization regarding

2. Coordination of Benefits without the claimant's consent;

3. To require that the claimant provide the Plan with information on such Other Plans so that this provision may be implemented;

4. To pay the benefits available under this Plan to an insurer or other organization if, in the opinion of the Plan, in its sole discretion, the insurer or other organization is entitled to them. Such benefits shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability; and

5. To recover payments whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of this provision, in accordance with the Plan's Recovery of Payments" provision.

Secondary Coverage

Covered Persons who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage.

The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over
An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Covered Persons Eligible for Medicare Benefits
To the extent required by federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be permitted to pay its benefits first. In these cases, benefits under this Plan will be calculated as secondary payer. The Covered Person will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Covered Person has enrolled for the full coverage. If the provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare-approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Beneficiaries Who Are Covered Under This Plan
If any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

If the Covered Person or their covered dependent has an injury or illness caused by a third party's act or omission, or if another party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Illness:

- The Plan specifically excludes coverage of claims for injury or illness for which a third party is liable;
- The Plan will conditionally pay benefits for that injury or illness subject to the Plan's Subrogation Provisions and **only** if the Covered Person or covered dependent (or their legal representative):
  - Will take no action which would prejudice the Plan's reimbursement or subrogation rights; and
  - Will cooperate in doing what is reasonably necessary to assist the Plan in enforcing our reimbursement or subrogation rights, including signing a Subrogation and Reimbursement Agreement upon the written request of the Plan. If you fail to execute the Subrogation and Reimbursement Agreement, the Plan may suspend payment of benefits for treatment related to the injury or illness caused by the third party, and seek reimbursement of any benefits already paid for such treatment.
- The Plan's reimbursement or subrogation rights will not be reduced because the recovery is not described as being related to medical costs or loss of income. The Plan is entitled to full reimbursement on a first-dollar basis, regardless of the characterization of the recovery.
- The Plan may enforce the Plan's reimbursement or subrogation rights by filing a lien with the third party, the third party's insurer or another insurer, or with a court having jurisdiction in this matter or any other appropriate party.
- The Plan may intervene at its own cost in any pending law suit to recover damages as a third-party plaintiff to protect its interests in any subrogated claim for benefits extended to treat the third-party liability injury. Should the Plan intervene to protect its interests, it may not contribute for the costs and attorney's fees pro rata extended by the Covered Person in pursuit of recovery.
- The Plan shall have an equitable lien and constructive trust in any and all recovery against the liable third party or its insurer to the full extent of the benefits paid on the Covered Person's behalf for such injury or illness, regardless of whether the recovery has been released to the Covered Person or whether the recovery is a traceable asset of the Covered Person.
- After reimbursement for benefits paid by the Plan, the Plan shall be relieved from any obligation to pay further benefits to the Covered Person or covered dependent for such injury or illness up to the entire net amount of the balance of the settlement or judgment recovered by the Covered Person or covered dependent.
- The Board of Trustees will review a request for waiver of subrogation rights, in part or in whole, in the event enforcement of the subrogation and reimbursement rights by the Plan would subject the Covered Person or covered dependent to undue hardship due to a lack of adequate insurance proceeds or recoverable funds. The Trustees have full discretionary authority in the determination of whether to waive any portion of the Plan's subrogation lien.
- In the case that the Covered Person enters into a contingency attorney's fee agreement with their attorney to recover from the liable third-party, the Plan will contribute to the costs of the Covered Person's attorney's fees and reasonable costs in obtaining a recovery of the benefits extended by the Plan on a pro rata basis (e.g., if the contingency fee if 1/3 of the gross recovery, the Plan will reduce its subrogation interest by 1/3). No reduction in the subrogation lien will occur in a matter recoverable from Workers' Compensation.

- The Plan may assert the provisions of this section against the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the representative has access or control of the Recovery.

- If a Covered Person does not comply with the provisions of this section, the Plan shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as Reimbursement to the Plan. The reductions will equal the amount of the required Reimbursement. The Plan further has to file suit against the Covered Person to recover the value of the benefits conditionally extended if the Covered Person does not honor their obligation to repay the Plan as set forth above. If the Plan must bring an action against a Covered Person to enforce the provisions of this section, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

GENERAL PROVISIONS

Clerical Error
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made, unless the error or delay is discovered more than six months after the effective date of coverage, in which event no adjustment will be made.

Conformity with Applicable Laws
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Summary Plan Description. It is intended that the Plan will conform to the requirements of any applicable law.

Interpretation
The use of masculine pronouns in this Summary Plan Description shall apply to persons of both sexes unless the context clearly indicates otherwise.

The use of the words, “you” and “your” throughout this Summary Plan Description applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

Headings
The headings used in this Summary Plan Description are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

Payment of Plan Costs
The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan. The amount of the Covered Person’s contribution (if any) will be determined from time to time by the Plan Sponsor, in its sole discretion.

Protection Against Creditors
No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan in its sole discretion may terminate the interest of such Covered Person or former Covered Person, his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Covered Person or former Covered Person, as the Plan may determine, any such application shall be a complete discharge of all liability with respect to such benefit payment.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits from this Plan, subject to the payment exception of the Health Insurance Portability and Accountability Act (HIPAA). In so acting, the Plan shall be free from any liability that may arise with regard to such action; however the Plan at all times will comply with the Privacy Standards and Security Standards of HIPAA. Any Covered Person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

Misrepresentation, False Statements or Fraud – Rescission of Coverage
The following actions by any Covered Person, or a Covered Person's knowledge of such actions being taken by another, constitute fraud and/or a material misrepresentation of fact and will result in immediate and retroactive termination to the date of such action of all coverage under this Plan for the entire Family of which the Covered Person is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;

2. Attempting to file a claim for a Covered Person for services which were not rendered or drugs or other items which were not provided;

    a. Providing false or misleading information in connection with enrollment in the Plan; or

    b. Providing any false or misleading information to the Plan.

Waiver
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Workers' Compensation
This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that a Covered Person received or is eligible to receive workers' compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid, without any reduction for costs of attorney's fees that the Covered Person or covered dependent may have expended to obtain the Workers' Compensation recovery. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement the Covered Person receives from workers' compensation. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

1. The workers' compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that the injury or illness was sustained in the course of or resulted from your employment;

3. The amount of workers' compensation benefits due specifically to health care expense is not agreed upon or defined by the Covered Person or the workers' compensation carrier; or

4. The health care expense is specifically excluded from the workers' compensation settlement or compromise.

You are required to notify the Plan immediately when a claim is filed for coverage under workers' compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so, or to reimburse the Plan for any expenses it has paid for which coverage is available through workers' compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

Not a Contract

This Summary Plan Description and any amendments constitute the terms and provisions of coverage under this Plan. The Summary Plan Description shall not be deemed to constitute a contract of any type between the Participating Employer and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this Summary Plan Description shall be deemed to give any employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Participating Employer to discharge any employee at any time.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Summary Plan Description. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Summary Plan Description for that information.**

Accident
"Accident" shall mean an event that is sudden, unexpected, unintended and over which the Covered Person has no control and that is caused by a non-infectious source external to the body.

Actively at Work or Active Employment
"Actively at Work" or "Active Employment" shall mean performance by the Employee of all the regular duties of his occupation at an established business location of the Participating Employer, or at another location to which he may be required to travel to perform the duties of his employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor. In no event will an Employee be considered Actively at Work if he has effectively terminated employment.

Allowable Charge
"Allowable Charge" means the actual costs (billed amount) charged for Medically Necessary services to the extent that such charges are Usual, Customary and Reasonable (UCR) for the area and the type of service, or are the Usual and Reasonable Charge for Outpatient Dialysis Treatment. For providers who participate in the PPO, the allowable charge is the discounted fee that the providers have agreed to accept under our agreements with them, except as provided by the Outpatient Dialysis Provision.

Ambulatory Surgical Center
"Ambulatory Surgical Center" shall mean any public or private establishment with an organized medical staff of Physicians, permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, continuous Physician services and registered professional nursing services, whenever a patient is in the facility, and which does not provide services or other accommodations for patients to stay overnight.

Benefit Period
"Benefit Period" shall mean a time period of one year commencing with the effective date of this Plan or the Plan anniversary. This Benefit Period will terminate on the earliest of the following date:

1. The last day of the one-year period;
2. The day the Plan benefit maximum applicable to the Covered Person becomes payable; or
3. The day the Covered Person ceases to be covered for benefits under this Plan.

Benefit Percentage
"Benefit Percentage" shall mean that percentage of Covered Expenses in excess of the Deductible amount, which the Plan pays. It is the basis used to determine any Out-of-Pocket Expenses in excess of the annual Deductible which are to be paid by the Employee.

Birthing Center
"Birthing Center" shall mean a facility that meets the following requirements:

1. Is licensed by the department responsible for the licensing of such facilities in the geographical area in which it is located;
2. Has permanent facilities which are equipped and operated mainly for childbirth; and
3. Provides continuous service by Physicians, registered nurses or midwife nurse practitioners when a patient is in the center.

Calendar Year
"Calendar Year" shall mean January 1 through December 31 of the same year.

Child or Children
"Child" or "Children" shall mean, in addition to the Employee's own blood descendant of the first degree or lawfully adopted child, a child placed with the Employee in anticipation of adoption, a child for whom coverage is an alternate recipient required under a QMCSO as required by the federal Omnibus Budget Reconciliation Act of 1993, any stepchild or any other child for whom the Employee has obtained legal guardianship. In order for a child to meet the Plan's definition of a dependent, the child must qualify as a dependent pursuant to IRS Code § 152 or AS Sec. 21.36.095.

Claims Administrator
"Claims Administrator" shall mean WPAS, Inc.

COBRA
"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended.

Confinement
"Confinement" shall mean being a resident patient in a Hospital for at least 15 consecutive hours per day. Successive Confinements are considered one Confinement unless:

1. It is due to a different or unrelated Injury or Illness causing the prior Confinement;

2. It is separated by 30 consecutive days when the Covered Person is not confined.

Convalescent Nursing Facility
"Convalescent Nursing Facility" shall mean a lawfully operated institution or that part of such an institution that meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for a person convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily activities;

2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;

3. It maintains a complete medical record on each patient;

4. It has an effective utilization review plan; and

5. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of Mental or Nervous Disorders.

The term shall also apply to expenses Incurred in an institution referring to itself as a Skilled Nursing Facility, extended care facility, convalescent nursing home or any other similar designation.

Convalescent Period
"Convalescent Period" shall mean a period of time commencing with the date of Confinement by the Covered
Person to a Convalescent Nursing Facility. Such Confinement must meet both of the following conditions:

1. The Confinement must have been for a period of not less than three consecutive days; and

2. The convalescent Confinement must commence within 14 days after the Covered Person is discharged from a Hospital and both the Hospital and convalescent Confinements must have been for the care and treatment of the same Illness or Injury. The convalescent Confinement

must be as an alternative to Hospitalization. The Plan may require that a Physician certify that the convalescent care is rendered as an alternative to Hospitalization.

Cosmetic or Cosmetic Procedure
"Cosmetic or Cosmetic Procedure" shall mean any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury

Covered Expenses
"Covered Expenses" shall mean the Allowable Charges Incurred by a Covered Person for any Medically Necessary treatments, services or supplies listed for coverage and not specifically excluded from coverage elsewhere in this Plan. For Outpatient Dialysis Treatment, "Covered Expenses" shall mean the Usual and Reasonable Charge Incurred by a Covered Person for any Medically Necessary treatments, services or supplies listed for coverage and not specifically excluded from coverage elsewhere in this Plan.

Covered Person
"Covered Person" shall mean a covered Employee and his or her covered Dependents who are eligible for benefits under the Plan.

Custodial Care
"Custodial Care" shall mean that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Covered Personin the activities of daily living. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such activities include, but are not limited to, bathing, dressing, feeding, preparation of meals or special diets, housekeeping, assistance in walking or in getting in and out of bed, and supervision over medication that can normally be self-administered.

Deductible
"Deductible" shall mean a specified dollar amount of Covered Expenses that must be Incurred during a Calendar Year and paid by the Covered Person before any additional Covered Expenses can be considered for payment at the Benefit Percentages stated in the Schedule of Benefits of this Plan.

Dental Hygienist
"Dental Hygienist" shall mean an individual who works under the supervision of a Dentist and is currently licensed to practice dental hygiene by a governmental authority that has jurisdiction over the licensure and practice of dental hygiene.

Dental Treatment Plan
"Dental Treatment Plan" shall mean the attending Dentist's written report of recommended treatment for a Period of Dental Treatment, on a form satisfactory to the Plan, which:

1. Itemizes the dental procedures required for the necessary care of the individual;

2. Shows the charges for each procedure; and

3. Is accompanied by any appropriate diagnostic material as may be required by the Plan.

Dentist
"Dentist" shall mean a licensed Dentist, dental surgeon or oral dental surgeon.

Dependent
"Dependent" shall mean:

1. The Employee's legal spouse, who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract or common law certification in the state of marriage of such parties.

2. The Employee's Child who is less than 26 years of age, including:

a. Natural children and legally adopted children, or

b. Step-children, foster children placed through a State foster child program, or children for whom you are the legal court-appointed guardian.

A covered Dependent Child who attains the limiting age while covered under the Plan shall remain eligible for medical benefits if ALL of the following exist at the same time:

1. He or she is mentally or physically handicapped;

2. He or she is incapable of self-sustaining employment;

3. He or she is dependent on the covered Employee for at least 50% of his or her support and maintenance; and

4. He or she is unmarried.

The Employee must furnish satisfactory proof to the Plan that the above conditions continuously exist on and after the date the limiting age is reached. The Plan may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the Plan, the Child's coverage shall cease on the date such proof is due.

The term Dependent excludes:

1. A spouse who is legally separated or divorced from the Employee. Such spouse must have met all requirements of a valid separation agreement or divorce decree in the state granting such separation or divorce; or

2. Any person on active military duty.

Durable Medical Equipment
"Durable Medical Equipment" shall mean equipment that is:

1. Able to withstand repeated use;

2. Primarily and customarily used to serve a medical purpose; and

3. Not generally useful for a person in the absence of Illness or Injury.

Emergency
"Emergency" means a medical 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 place the health of the individual or unborn child in serious jeopardy, to expose the individual to serious impairment of bodily functions, or result in serious dysfunction of any organ or body part.

Employee
"Employee" shall mean a person who is a regular employee of the Participating Employer, regularly scheduled to work at least 20 hours per week, or at least 4 hours per day, for the Participating Employer in an employer-employee relationship, and who meets the eligibility requirements of this Plan.

Experimental and/or Investigational
The Plan or its designee has the discretion and authority to determine if a drug, service or supply is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan or its designee (based on the information and resources available at the time the service was performed or the drug or supply was provided, or the service, drug, or supply was considered for preauthorization under the Plan's Utilization Management programs), any of the following conditions were present with respect to one or more essential provisions of

the drug, service or supply:

- The drug, service or supply is described as an alternative to more conventional therapies in written documents by the health care provider that performs the service or prescribes the supply;

- A drug, service, supply, care or treatment does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

- The prescribed drug, service or supply may be given only with approval of an institutional review board as defined by federal law;

- There is an absence of authoritative medical or scientific literature on the subject, or that literature indicates that the drug, service or supply is Experimental and/or Investigational or that more research is needed;

- Food and Drug Administration (FDA) has not approved marketing of the drug, service or supply or has it under consideration;

- The drug, service or supply is available only through clinical trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

The Plan will investigate claims that might be considered Experimental or Investigational. The Plan may consult with medical professionals to determine whether the treatment is excluded as Experimental or Investigational.

Family
"Family" shall mean a covered Employee and his or her covered Dependents.

FMLA
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

FMLA Leave
"FMLA Leave" shall mean a leave of absence, which the Participating Employer is required to extend to an employee under the provisions of the FMLA.

HIPAA
"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency
"Home Health Care Agency" shall mean a public or private agency or organization that specializes in providing medical care and treatment in the home. It must meet all of the following conditions:

1. It is primarily engaged in providing skilled nursing and other therapeutic services and is duly licensed, if required, by the appropriate licensing authority;

2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one Registered Nurse to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse;

3. It maintains a complete medical record on each individual; and

4. It has a full-time administrator.

Hospice
"Hospice" shall mean a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons who are Terminally Ill.

Hospice Benefit Period
"Hospice Benefit Period" shall mean a specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a prognosis of Terminally Ill, and the Covered Person is accepted into a Hospice program. The period shall end the earliest of six months from this date or at the death of the Covered Person. A new Hospice Benefit Period may begin if the attending Physician certifies that the patient is still Terminally Ill; however, the Plan may require additional proof before a new Hospice Benefit Period can begin.

Hospice Care
"Hospice Care" shall mean care rendered as part of a Hospice Care Program to a Terminally Ill Covered Person by or under arrangements with a Hospice Care Agency.

Hospice Care Agency
"Hospice Care Agency" shall mean an agency or organization that meets all of the following tests:

1. Has Hospice Care available 24 hours a day;
2. Is licensed as such by the jurisdiction it is in;
3. Provides:
    a. Skilled nursing services;
    b. Medical social services;
    c. Psychological and dietary counseling; and
4. Provides or arranges for other services which will include:
    a. Services of a Physician;
    b. Physical or Occupational Therapy;
    c. Part-time or home health aide services consisting of primarily caring for a Terminally Ill family member; and
    d. Inpatient care in a facility when needed for pain control and other acute and chronic symptom management.

Hospice Care Facility
"Hospice Care Facility" shall mean a facility, or a distinct part of a facility, such as a Hospital or Convalescent Nursing Facility, that meets all of the following tests:

1. Is established , equipped and operated mainly as a setting for providing Inpatient Hospice Care to Terminally Ill persons;
2. Charges for the services and supplies it provides;
3. Is licensed as such by the jurisdiction it is in;
4. Keeps medical records on each patient;
5. Provides an ongoing quality assurance program with reviews by M.D.s or D.O.s other than those who own or direct the facility;

6. Is run under the direction of a staff M.D. or D.O. At least one such Physician must be on call at all times;
7. Provides 24-hour-a-day skilled nursing services under the direction of Registered Nurses;
8. Has a full-time administrator; and
9. Has personnel which includes at least:
    a. One Physician;
    b. One Registered Nurse;
    c. One licensed or certified social worker (LSW/CSW) employed by the agency;
    d. One pastoral or other counselor; and
10. Has established policies governing the provisions of Hospice Care;
11. Assesses the patient's medical and social needs and develops a Hospice Care Program to meet those needs;
12. Permits all area medical personnel to utilize its services for their Terminally Ill patients; and
13. Utilizes volunteers trained in providing services to Terminally Ill patients to meet their non-medical needs.

Hospice Care Program
"Hospice Care Program" shall mean a written plan of Hospice Care, which:

1. Is established by and periodically reviewed by:
    a. A Physician attending the Covered Person; and
    b. Appropriate personnel of a Hospice Care Agency;
2. Is designed to provide palliative and supportive care to Terminally Ill persons; and
3. Includes an assessment of the medical and social needs, and a description of the care to be rendered to meet those needs.

Hospital
"Hospital" shall mean an institution that meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;
2. It is constituted, licensed and operated in accordance with the applicable laws of the jurisdiction in which it is located;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury;
4. Such treatment is provided for compensation by and under the supervision of Physicians with continuous 24-hour nursing services by Registered Nurses;
5. It qualifies as a hospital or a Psychiatric Hospital and is licensed by the appropriate state authority; and

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics or a nursing home.

Illness or Sickness
"Illness" or "Sickness" shall mean a bodily disorder, disease, physical sickness, mental infirmity, functional nervous disorder, pregnancy or complications of pregnancy of a Covered Person. A recurrent Illness will be considered one Illness.

Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

Incurred
"Incurred" shall mean that a Covered Expense is incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury
"Injury" shall mean physical damage to the body, caused by an external force, and which is due directly and independently of all other causes, to an accident.

Inpatient
"Inpatient" shall mean the classification of a Covered Person when that person is admitted to a Hospital, Hospice or Convalescent Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such admission.

Intensive Care Unit
"Intensive Care Unit" shall mean a section, ward or wing within a Hospital, which is separated from other facilities, and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;

2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and

3. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

Licensed Practical Nurse
"Licensed Practical Nurse" shall mean an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

Medically Necessary
"Medically Necessary" shall mean any health care treatment, service or supply determined by the Planto meet each of these requirements:

1. It is ordered by a Physician for the diagnosis or treatment of an Illness or Injury;

2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that omissions would adversely affect the person's medical condition; and

3. It is furnished by a provider with appropriate training, experience, staff and facilities to furnish that particular service or supply.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition, and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

The Plan will determine whether these requirements have been met based upon published reports in authoritative medical and scientific literature; regulations, reports, publications or evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institute of Health, and the Food and Drug Administration (FDA); listings in the following compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information and The United States Pharmacopoeia Dispensing Information; and other authoritative medical sources to the extent that the Plan, in its sole discretion, determines them to be necessary. The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not in and of itself, make the service or supply Medically Necessary.

Medicare
"Medicare" shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental or Nervous Disorder
"Mental or Nervous Disorder" shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Newborn
"Newborn" shall mean an infant from the date of birth until the initial Hospital discharge, or until the infant is 14 days old, whichever occurs first.

Nurse Midwife
"Nurse Midwife" shall mean a Registered Nurse who is licensed as a midwife by the state in which the services are provided.

Occupational Therapy
"Occupational Therapy" shall mean a program of care that focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's ability to use his or her fingers and hands (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment. Therapy which is intended to address primarily vocational rehabilitation issues (i.e., return to work skills) will not be considered a Covered Expense under this Plan.

Optometrist
"Optometrist" shall mean a licensed optometrist.

Oral Surgery
"Oral Surgery" shall mean maxillofacial surgical procedures limited to:

1. Excision of neoplasms including benign, malignant and pre-malignant lesions, tumors and cysts;

2. Incision and drainage of abscess;

3. Surgical procedures involving accessory sinuses, salivary glands and ducts; and

4. Removal of impacted teeth.

Orthotic Appliance
"Orthotic Appliance" shall mean any device or appliance for the correction or prevention of musculoskeletal deformities or disorders involving joints, muscles and other supporting structures, such as ligaments and cartilage.

Out-of-Pocket Maximum Expense
"Out-of-Pocket Maximum Expense" shall mean the total dollar amount the Covered Person will be required to pay, **excluding** the Deductible and penalties, expenses in excess of stated maximums and limits, for Covered Expenses under the Plan.

Outpatient
"Outpatient" shall mean the classification of a Covered Person when that Covered Person receives medical care, treatment, services or supplies at a clinic, a Physician's office at a Hospital, if not a registered bed patient at that Hospital, an outpatient psychiatric facility or an Outpatient Substance Abuse Treatment Facility.

Outpatient Substance Abuse Treatment Facility
"Outpatient Substance Abuse Treatment Facility" shall mean an administratively distinct governmental, public, private or in dependent unit or part of such unit that provides Outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

Participating Employer
"Participating Employer" shall mean Juneau City and Borough School District and APEA-AFT, or any other Employer participating under a special participation agreement with approval of the Board of Trustees.

Period of Dental Treatment
"Period of Dental Treatment" shall mean all treatment performed in the oral cavity during one or more sessions as the result of the same initial diagnosis, and shall include any complications arising during such treatment.

Physician
"Physician" shall mean a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, podiatrist, certified consulting Psychologist or psychiatrist to the extent that same, within the scope of their license, are permitted to perform services provided in this Plan. The term "Physician" also includes a Nurse Midwife, a nurse practitioner, and a social worker with the degree "MSW".

Physical Therapy
"Physical Therapy" shall mean a plan of care provided to return a patient to the highest level of motor functioning possible. The physical therapist extensively evaluates the patient's muscle tone, movement, balance, endurance, ability to ambulate, ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint), the therapist evaluates the patient's ability to use the equipment and determines the correct size and type of equipment for the specific patient. The therapist constructs a program of exercises and movements to maximize the patient's motor skills.

Plan
"Plan" shall mean the APEA-AFT Health & Welfare Trust Employee Benefit Plan.

Plan Administrator
"Plan Administrator" shall mean the APEA-AFT Board of Trustees.

Plan Fiduciary
Plan Fiduciary shall mean the APEA-AFT Board of Trustees.

Plan Sponsor
"Plan Sponsor" shall mean APEA-AFT.

Plan Year
"Plan Year" shall mean a period of time beginning with the Effective Date of this Plan or the anniversary of that date and ending on the day before the next anniversary of the Effective Date of this Plan.

Pregnancy
"Pregnancy" shall mean that physical state which results in childbirth, abortion or miscarriage.

Privacy Standards
"Privacy Standards" shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

Provider
Provider shall means a state licensed Physician, Physician assistant, dentist, osteopath, Optometrist, chiropractor, Nurse Midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, marital and family therapist, Psychologist, Psychological associate, licensed clinical social worker, licensed acupuncturist, certified direct-entry midwife, licensed professional counselor (LPC) or other practitioner or facility defined or listed herein, or approved by the Plan.

Psychologist
"Psychologist" shall mean a licensed Psychologist or psychological associate.

Qualified Treatment Facility
"Qualified Treatment Facility" shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, Psychiatric Day Treatment Facility, Substance Abuse Facility, alternative Birthing Center, Home Health Care Agency, or any other such facility that the Plan approves.

Registered Nurse
"Registered Nurse" shall mean an individual who has received specialized nursing training, is authorized to use the designation of "R.N.," and is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Rehabilitation Center
"Rehabilitation Center" shall mean a legally operating institution or facility providing a program of coordinated and integrated services, including evaluation and treatment with an emphasis on education and training of those who have severe disabling impairments of recent onset or recent progression, or those who have had prior exposure to rehabilitation and require an identifiable intensity of services. It must be under the supervision and direction of one or more Physicians with 24-hour nursing care provided by Registered Nurses. The institution or center may not be used as a place of rest, as a nursing home or a place for the aged.

Room and Board
"Room and Board" shall mean all charges by whatever name called which are made by a Hospital, Hospice, or Convalescent Nursing Facility as condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

Security Standards
"Security Standards" shall mean the standards relating to the electronic transmission of individually identifiable health information, as pursuant to HIPAA.

Semi-Private
"Semi-Private" shall mean a class of accommodations in a Hospital or Convalescent Nursing Facility in which at least two patient beds are available per room.

Skilled Nursing Facility
"Skilled Nursing Facility" shall mean an institution or a distinct part of one that is operating pursuant to the law for such an institution. In addition the Plan requires that:

1. Its main purpose is to provide 24-hour-a-day accommodations and skilled nursing care for patients recovering from Sickness or Injury;

2. It is not used mainly as a place for the aged, drug addicts, alcoholics, the mentally ill, or a place for rest;

3. It is licensed by the appropriate state authority and/or approved by Medicare;

4. It is under the full-time supervision of a Physician or Registered Graduate Nurse;

5. The patient's plan of care is prescribed by a Physician and updated at least every 30 days;

6. It has an agreement to have Physician's services available when needed;

7. It maintains adequate medical records for all patients;

8. It has written transfer agreement with at least one Hospital; and

9. It is approved as such by Medicare.

Speech Therapy
"Speech Therapy" shall mean a program of care that evaluates the patient's motor-speech skills, expressive and receptive language skills and writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his or her social interaction skills such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient's speech, listening and conversational skills, and higher level cognitive skills such as understanding abstract thought, making decisions and sequencing. Therapy may be considered medically appropriate even for patients who do not have apparent speech problems, but who do have deficits in higher level language functioning as a result of trauma or identifiable organic disease process.

Substance Abuse
"Substance Abuse" shall mean a condition, certified by a Physician, to be primarily alcoholism or drug dependency.

Terminally Ill
"Terminally Ill" shall mean a medical prognosis of six months or less to live.

Uniformed Services
"Uniformed Services" shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

USERRA
"USERRA" shall mean The Uniformed Services Employment and Reemployment Rights Act, a federal law, effective October 13, 1994.

Usual, Customary and Reasonable
"Usual, Customary and Reasonable" shall mean the charge the Plan determines to be the prevailing rate charged in the geographic area where the service is provided, or the provider's usual charge, whichever is less.

In some cases, data may be insufficient to determine a UCR rate. The Plan may consider items such as the following:

- The prevailing charges in a greater geographic area,
- The complexity of the service or supply,
- The degree of skill needed,
- The type or specialty of the provider, and
- The range of services or supplies provided by a facility.

The Plan makes the final determination as to whether or not the fee is Usual Customary and Reasonable. Charges or fees in excess of the UCR charge are your responsibility to pay.

Usual and Reasonable Charge for Outpatient Dialysis Treatment
"Usual and Reasonable Charge for Outpatient Dialysis Treatment" means with respect to dialysis-related claims, the Plan shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

HIPAA NOTICE OF PRIVACY PRACTICES

The APEA-AFT Health & Welfare Trust Fund is committed to protecting the privacy of Covered Persons. This notice describes the medical information practices of the Plan and those of any third party that assists in the administration of the Plan. The Plan keeps a record of all health care claims paid under the Plan, as well as enrollment and other demographic information and records. This notice applies to all of the medical records the Plan maintains, as well as other personal information that the Plan has obtained about Covered Persons. Some of that information is considered "protected health information" and is subject to the federal protections afforded by the Health Insurance Portability and Affordability Act (HIPAA).This notice provides information about how the Plan may use or disclose medical information that is considered PHI and what the Covered Person's rights are with respect to such information. This Notice also applies to any organization that assists in the administration of the Plan. Doctors or health care provider may have different policies or notices regarding their use and disclosure of medical information created by the doctor's office, the clinic, or the hospital.

The Plan is required by law to:

- ensure that medical information that identifies a Covered Person is kept confidential;
- give the Covered Person this notice of the legal duties and privacy practices related to medical information that the Plan maintains about the Covered Person; and
- follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Medical Information

The following categories describe methods that the Plan uses and discloses medical information. All of the methods the Plan uses will fall into one of these categories; however, the examples listed are fairly broad, and every possible use or disclosure in a category cannot be listed here.

- **For Payment Purposes** – The Plan may use and disclose medical information about a Covered Person to determine eligibility for Plan benefits, to facilitate payment for the treatment and services that a Covered Person receives from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may communicate with a Covered Person's health care provider about the Covered Person's medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. The Plan also may share a Covered Person's medical information with a utilization review or precertification service provider or with another entity to assist with the settlement or subrogation of health claims. Also, the Plan may share a Covered Person's medical information to aid in coordination of benefits with another group health plan.

- **For Health Care Operations** – The Plan may use and disclose medical information about a Covered Person for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, a Covered Person's medical information may be used when the Plan conducts quality assessment and improvement activities, or for underwriting, premium rating, and other activities related to Plan coverage, such as submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud- and abuse-detection programs; cost management; and general Plan administrative activities.

- **As Required By Law** – The Plan will disclose medical information about a Covered Person when the Plan is required to do so by federal, state, or local law. For instance, The Plan may disclose medical information when required by a court order in a litigation action such as medical malpractice.

- **To Avert a Serious Threat to Health or Safety** – The Plan may use and disclose medical information about a Covered Person when necessary to prevent a serious threat to your health or safety or to the health or safety of another or the public. Any such disclosure would only be allowed to someone able to help prevent the threat. For example, in the case of an inquest into the licensure of a physician.

- **Organ and Tissue Donation** – If a Covered Person is an organ or tissue donor, the Plan may release medical information about the Covered Person to organizations that handle the organ procurement; or organ, eye, or tissue transplantation; or to an organ bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans** – If a Covered Person is a member of the armed forces, the Plan may release medical information about the Covered Person as required by military command authorities.

- **Workers' Compensation** – the Plan may release medical information about a Covered Person to workers' compensation or similar programs.

- **Public Health Risks –** Medical information about a Covered Person may be released for public health activities, which generally include: **-** to prevent or control disease, injury, or disability;
  - to report births or deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to notify the appropriate government authority if there is reasonable cause to believe that a Covered Person has been the victim of abuse, neglect, or domestic violence. The Plan will make these disclosures only if the Covered Person agrees or if they are required or authorized by law.

- **Health Oversight Activities** – The Plan may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. The government uses these activities to monitor the health care system, for government programs, and for compliance with civil rights.

- **Lawsuits and Disputes** – If a Covered Person is involved in a lawsuit or dispute, The Plan may disclose medical information about the Covered Person in response to a court or administrative order, subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to tell the Covered Person about the request or to obtain an order protecting the information.

- **Law Enforcement** – The Plan may release medical information if requested by a law enforcement official:
  - in response to a court order, subpoena, warrant, summons, or similar process;
  - to identify or locate a suspect, fugitive, material witness, or missing person;
  - about the victim of a crime if, under limited circumstances, the Plan is unable to obtain the person's agreement;
  - about a death the Plan believes may be the result of criminal conduct;
  - about criminal conduct at a hospital; or
  - in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors** – The Plan may release medical information about a Covered Person to a coroner or medical examiner, or to a funeral director, as may be necessary for them to carry out their duties.

- **National Security and Intelligence Activities** – The Plan may release medical information about a Covered Person to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Inmates** – If a Covered Person is an inmate of a correctional institution or in the custody of a law enforcement official, the Plan may release medical information about the Covered Person to the correctional institution or the law enforcement official, if necessary for (1) the institution to

provide the Covered Person with health care, (2) to protect the Covered Person's health or safety or the health or safety of others, or (3) for the safety and security of the correctional institution.

The Plan will release or disclose only the minimum necessary information needed for the specific purpose of the use or disclosure under any of the foregoing categories in accordance with HIPAA.

Other Uses of Medical Information
Other uses and disclosures of medical information not covered by this notice or the laws that apply to the Plan offered through the Plan will be made only with a Covered Person's written permission. The Plan is specifically prohibited from using or disclosing psychotherapy notes without our prior authorization. The Plan further cannot use a Covered Person's medical records for marketing purposes, sell a Covered Person's medical records, disclose a Covered Person's medical records for any purpose not described in this notice, or to use medical records that include genetic information for underwriting purposes.

Release of Medical Information Subject to Authorization
If a Covered Person provides the Plan with permission to disclose medical information, the Covered Person may revoke that permission at any time, in writing. The Plan will require that the Covered Person completes an Authorization for Release of Protected Health Information and return it to the Plan Administration Office before such information will be provided to a third party. A Covered Person has the right also to revoke the Authorization, but such revocation must also be in writing and directed to the Plan Administrative Office. If a Covered Person revokes permission to disclose medical information, the Plan will no longer use or disclose medical information about the Covered Person for the reasons covered the written authorization after the date of receipt of the revocation.

A Covered Person's Rights Regarding Medical Information about the Covered Person
A Covered Person has the following rights regarding medical information that the Plan maintains:

- **Right to Inspect and Copy Medical Records.** A Covered Person may inspect and copy medical information that the Plan may use to make decisions about the Covered Person's Plan benefits. To inspect and copy such information, a Covered Person must submit a request in writing to the Plan Administrator at 211 4th Street, Suite 306, Juneau, Alaska 99801. If a Covered Person requests a copy of the information, the Covered Person may be charged a reasonable fee for the costs of copying, mailing, or other supplies associated with the request. In very limited circumstances, a Covered Person's request to inspect or copy records may be denied. If a Covered Person is denied access to the medical information, the Covered Person may request that the denial be reviewed by the Board of Trustees.

- **Right to Amend Medical Records.** If a Covered Person feels that medical information maintained by the Plan is incorrect or incomplete, the Covered Person may request that the information be amended. To request an amendment, the request must be made in writing to the Plan Administrator at 211 4th Street, Suite 306, Juneau, Alaska 99801. Also, a Covered Person must provide a reason to support the request. The Plan may deny the request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny the request if a Covered Person asks to amend information (1) that is not part of the medical information kept by the Plan or for our use; (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information that a Covered Person would be permitted to inspect or copy; or (4) is accurate and complete.

- **Right to an Accounting of Disclosures.** A Covered Person has the right to request an accounting of disclosures if those disclosures were made for any purpose *other than* treatment, payment, or health care operations. To request a list or accounting of disclosures, a Covered Person must submit the request in writing to the Plan Administrator 211 4th Street, Suite 306, Juneau, Alaska 99801. Your request must state the time period for which a Covered Person requires a list or accounting of disclosures, but the period may not exceed six years. The

request should indicate in what form the Covered Person wants the accounting (paper or electronic). The first list that a Covered Person requests within a 12-month period will be provided without charge. However, the Plan may charge for the cost of providing additional requests. A Covered Person will be notified of the approximate cost involved prior to providing the Covered Person with a response to additional requests, and the Covered Person may choose to withdraw or modify the request at that time, before costs are assessed.

- **Right to Request Restrictions.** A Covered Person may request a restriction or limitation of the medical information the Plan uses or discloses about the Covered Person for treatment, payment, or health care operations. A Covered Person also may request a limit on the medical information that is disclosed about the Covered Person to someone who is involved in the Covered Person's care or the payment for care, such as a family member or caregiver. For instance, a Covered Person may request that the Plan not disclose information about a particular medical treatment. The Plan is *not* required to agree to the request. To request restrictions, a Covered Person must make the request in writing to the Plan Administrator at 211 4th Street, Suite 306, Juneau, Alaska 99801. The request must state (1) what information the Covered Person wants to limit; (2) whether the Covered Person wants to limit our use or disclosure or both; and (3) to whom the Covered Person wants the limits to apply.

- **Right to Request Confidential Communications.** A Covered Person may request that the Plan communicate with the Covered Person about medical matters in a certain way or at a certain location, such as only at the Covered Person's home address or only by mail. To request confidential communications, the Covered Person must make the request in writing to the Plan Administrator at 211 4th Street, Suite 306, Juneau, Alaska 99801. The Plan will accommodate all reasonable requests. The request must specify how and where the Covered Person wishes to be contacted.

- **Right to a Paper Copy of this Notice.** A Covered Person may request a paper copy of this notice. A Covered Person may also ask that the Covered Person be given a copy of this notice at any time. Even if the Covered Person has agreed to receive notices and communications electronically, the Covered Person is still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Plan Administrator at 211 4th Street, Suite 306, Juneau, Alaska 99801, Telephone Toll Free: (800) 478-9991, Local: (907) 789-0182.

Complaints

If a Covered Person believes his or her privacy rights have been violated, the Covered Person may file a complaint with the hospital, doctor or clinic, or with the Department of Health and Human Services. To file a complaint with the Plan, contact the Plan Administrator at 211 4th Street, Suite 306, Juneau, Alaska 99801. All complaints must be submitted in writing.

GENERAL PLAN INFORMATION

Name of Plan:	APEA-AFT Health & Welfare Trust Employee Benefit Plan
Plan Administrator: **(Named Fiduciary)**	APEA-AFT Board of Trustees 211 Fourth Street, Suite 306 Juneau, AK 99801 Phone (907) 586-2334 (Fax) (907) 463-4980
Plan Sponsor Tax ID No.:	52-7332235
Fiscal Year:	July 1 through June 30
Plan Year:	September 1 through August 31
Plan Type:	Medical, Dental, Vision, Prescription Drug
Claims Administrator:	Welfare & Pension Administration Service, Inc. 2815 Second Avenue, Suite 300 PO Box 34203 Seattle, WA 98124-1203 800-331-6158 www.wpas-inc.com
Participating Employer(s):	Juneau City and Borough School District and APEA-AFT
Agent for Service of Legal Process:	APEA-AFT Health & Welfare Trust