APEA-AFT Health and Welfare Trust

BENEFIT GUIDE

JUNEAU EDUCATION SUPPORT STAFF (JESS)

Effective Date: March 1, 2006
Restatement Date: January 1, 2021

KEY CONTACTS

<table>
<tr><th colspan="2">IT'S EASY TO GET ANSWERS ONLINE</th></tr>
<tr><td colspan="2" align="center">Go to:

WWW.APEA-AFTTRUST.COM</td></tr>
<tr><td>For <u>general benefit</u> information, you don't need to log in.

Here's where you'll find:
Forms
Health Plan Booklet
Notices
PIN request forms
Important links
Contact info</td><td>For <u>personal benefit</u> information, log-in securely.

Here's where you'll find:
The status of your processed claims
Your eligibility status
Enrolled dependents
Beneficiary designation
For secure login, you'll need:
Your social security number or your WPAS ID number
Your assigned PIN: To get a PIN, submit a PIN Request Form.
Spouses and dependents over age 13 must request their own PIN.
For help with website access, call 800-732-1121, option 4.</td></tr>
</table>

FOR INFORMATION ON THESE TOPICS…	HERE'S WHO TO CALL …
• Eligibility and enrollment • Medical or dental benefits and claims • COBRA continuation coverage • Updating your personal information • Claim appeals • Medical information requests • Complaints	**Plan Administrator:** Welfare & Pension Administration Service, Inc. • Website: www.apea-afttrust.com • Phone: 800-331-6158 Mail dental and member paid medical claims to: APEA-AFT Health Benefits Trust PO Box 34840 Seattle, WA 98124-1840 Providers file medical claims to: Aetna: www.aetna.com PO Box 98110 El Paso TX 79998-1106

FOR INFORMATION ON THESE TOPICS…	HERE'S WHO TO CALL …
• Prescription drug benefits and claims • Locating a retail pharmacy • Using the mail-order pharmacy	**CVS Caremark** • Website: https://www.caremark.com/ • Phone: 866-818-6911 • Mail Order Claims: PO Box 94467, Palatine, IL 60094-4467 • Retail Paper Claims: PO Box 52136, Phoenix, AZ 85072-2136
Vision Plan benefits and claims Locating a VSP Provider	**Vision Service Plan (VSP)** • Website: www.vsp.com • Phone: 800-877-7195 • Mail (Out-of-Network Claims): PO Box 385018, Birmingham, AL 35238-5018
Pre-certification for surgery and hospital admission Case management for long-term conditions	**Medical Rehabilitation Consultants** • Website: www.medrehabconsultants.com • Phone: 800-827-5058 • Mail: 111 W Cataldo Ave., Spokane, WA 99201
Find a provider in the Aetna network	**Aetna** • Website: www.aetna.com/docfind; select the "Aetna Choice ® POS II (Open Access) network" or login to the Aetna website
View available services and details	**Mat-Su Regional Medical Center** • Website: www.matsuregional.com • Phone: 907-861-6000 • Address: 2500 S. Woodworth Loop, Palmer, AK 99645
Make an appointment at the CHC Find out hours the clinic is open View available services	**Coalition Health Center (CHC)** • Website: www.coalitionhealthcenter.com • Anchorage Coalition Health Center o Phone: 907-265-1370 o Address: 2741 Debarr Road, Suite C210, Anchorage, AK 99508 • Fairbanks Coalition Health Center o Phone: 907-450-3300 o Address: Ridgeview Business Park, 575 Riverstone Way, Unit 1, Fairbanks, AK 99709
Register for telemedicine service Request an appointment online or by phone	**Teladoc** • Website: www.teladoc.com • Phone: 800-TELADOC (835-2362)
Surgery benefit coverage details Planning surgery Information on surgical procedures	**BridgeHealth** • Website: https://www.bridgehealth.com/; use company code: AKHWT • Phone: 844-249-8108

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WELCOME

APEA-AFT HEALTH AND WELFARE TRUST

The APEA-AFT Health and Welfare Trust was established to provide health care benefits for eligible members and their dependents.

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 a 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.

SIX TIPS TO MAKE THE MOST OF YOUR BENEFITS

When you use your benefits wisely, you save money for yourself and the Plan:

1. Choose Aetna Preferred Providers to get discount pricing and avoid billed charges above the Plan's allowed amount.
2. Stay healthy with recommended preventive care, covered at 100%, no deductible required.
3. Consider using BridgeHealth for planned surgical services.
4. Use Teladoc for telephonic and video access to a doctor 24 / 7 / 365 at no cost to you.
5. Always ask your doctor if a generic drug is right for you. (And use the mail-order service to fill prescriptions you take regularly.)
6. If you have questions about your coverage, get answers before you receive health care services.

Please refer to this Plan Booklet for details about your benefits, and keep it handy for future reference.

REQUIRED NOTICES

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 800-331-6158.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa. 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.healthcare.gov.

Establishment of the Plan; Adoption of the Plan Document and Summary Plan Description

This Plan Document and Summary Plan Description, made by the Board of Trustees of APEA-AFT Health and Welfare Trust as of January 1, 2020, hereby amends and restates the APEA-AFT Health and Welfare Trust employee Benefit Plan (the "Plan"), which was originally adopted by the Board of Trustees, effective March 1, 2006.

The Board of Trustees 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 Board of Trustees has caused this Summary Plan Description to be executed.

APEA-AFT Health and Welfare Trust

WE'RE HERE TO HELP

When you have questions about your Health Plan, please call the Plan Administrator at 800-331-6158 or use the Trust website: www.apea-afttrust.com.

Please see contact information for other services under Key Contacts at the front of this Guide.

ELIGIBILITY AND ENROLLMENT

Employee Coverage

New employees are eligible for coverage on the first day of the month following a 60-day waiting period. You have 31 days from your date of hire to enroll.

If you begin work with an initial probationary period:

- The first month is considered an orientation period
- The 60-day waiting period begins following the orientation period

An employee must:

- Be a regular employee of the participating employer
- Be 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
- Meet the eligibility requirements of this Plan

You must actually begin work for the participating employer in order to be eligible.

If you are an eligible employee of more than one participating employer, you may be covered as the employee of only one employer.

DON'T MISS THIS DEADLINE!
Enroll within 31 days from your date of hire. You'll have to wait until the next annual Open Enrollment period to enroll if you miss your initial enrollment opportunity.

Eligible Dependents

You may enroll your eligible dependents for benefit coverage on the latest of the following dates:

- The date you become eligible to enroll dependents
- The date your dependent becomes eligible for coverage
- The date you acquire a dependent

Your eligible dependents include:

- Your legal spouse, who is a resident of the same country in which you reside. Your spouse must meet all requirements of a valid marriage contract or common law certification of the state in which you were married.
- Your child who is less than 26 years of age, including:
  - Natural children and legally adopted children
  - Stepchildren, foster children placed through a state foster child program, or children for whom you are the legal court-appointed guardian

The following individuals are not eligible dependents:

- A spouse who is legally separated or divorced from you (the employee). The spouse must meet all requirements of a valid separation agreement or divorce decree in the state where you become separated or divorced.
- Anyone who is on active military duty

DISABLED CHILDREN OVER 26

After the dependent's child's 26th birthday, he or she remains eligible for health benefits if ALL of the following exist at the same time:

1. He or she is mentally or physically disabled, and
2. He or she is incapable of self-sustaining employment, and
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.

You must provide satisfactory proof to the Plan Administrator that the above conditions continuously exist on and after the child's 26th birthday.

The Plan Administrator may not request proof more often than annually after two years from the date you provide the first proof. If you do not submit satisfactory proof to the Plan Administrator, the child's coverage will end on the date the proof is due.

REQUIRED DEPENDENT DOCUMENTATION

To enroll your eligible dependents, you must provide documentation that they are eligible dependents.

Examples of dependent documentation are:

- Spouse: Copy of marriage certificate
- Natural child: Copy of birth certificate listing the employee as mother or father; or a Qualified Medical Child Support Order
- Adopted child: Proof of legal adoption or placement with you in anticipation of adoption
- Stepchildren: Copy of birth certificate listing your spouse as mother or father
- Foster children or children for whom you have legal responsibility: Proof of legal custody or guardianship

No claims will be paid on your dependents until acceptable documentation is on file at the Plan Administrator.

GET YOUR CLAIMS PAID ON TIME

Do your part to make sure your claims are paid on time by providing all the required dependent documentation to the Plan Administrator.

When Coverage Begins

You must enroll within 31 days of the date you become eligible for benefit coverage. For example:

YOUR ELIGIBILITY DATE	YOU MUST ENROLL WITHIN 31 DAYS	YOUR EFFECTIVE DATE
Mar. 1	Apr. 1	Mar. 1

When the Plan Administrator receives your completed enrollment forms within 31 days of your eligibility date, your coverage becomes effective. on your eligibility date.

If you do not enroll within 31 days of eligibility, you must wait until the Plan's annual Open Enrollment period. If you experience a qualifying event, you may make midyear benefit changes; see next section for details.

If you are not actively at work due to a reason other than a medical condition on your effective date, your coverage becomes effective on the date you return to active employment.

WHEN DEPENDENT COVERAGE BEGINS

Your dependent's effective date begins on the earliest of the following dates:

DEPENDENT STATUS	EFFECTIVE DATE
Dependents you enroll at the same time as your initial enrollment	Your effective date
A dependent you enroll within 31 days of when he or she becomes eligible	The first day of your dependent's eligibility
Your newborn dependent child or a child you adopt or is placed with you for adoption	From the moment of birth or adoption, and for the first 31 days **To continue coverage beyond this 31-day period, you must enroll the child during the first 31-day period**
NOTE: Your dependent's effective date may not be earlier than your effective date of coverage.	

If you do not enroll your dependent within 31 days of your date of hire, you must wait until the Plan's annual Open Enrollment period. If you experience a qualifying event, you may make midyear benefit changes; see next section for details.

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:

- Your first day back at work
- The first day of the coverage period for which the employer and employee contributions are received by the Plan Administrator .

RETURNING FROM LAYOFF

If you were covered by the Plan prior to going on layoff and you return to work within two years, 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.

Election Changes

OPEN ENROLLMENT

Open Enrollment takes place prior to the beginning of each Plan Year. During the Open Enrollment period, an employee may elect or decline coverage and may add or delete any dependents.

Changes made during Open Enrollment will be effective at the beginning of the next Plan Year (September 1).

Normally, changes cannot be made outside of Open Enrollment.

> **MIDYEAR FAMILY CHANGES?**
>
> If your family changes during the year—for example, you get married, separated or divorced, or have or adopt a baby—you don't have to wait until Open Enrollment to add or drop dependents. Just be sure to notify the Plan Administrator within 31 days of the qualifying event. You may obtain an enrollment form on the Trust website: www.apea-afttrust.com.

QUALIFYING EVENTS

If you experience a qualifying event during the year, you may change your benefits by contacting the Plan Administrator and making a new election within 31 days of the qualifying event.

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

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 Administrator 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 first of the month after the Plan Administrator receives your new election form.

MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you did not enroll yourself or your eligible dependent when initially eligible, you may be permitted to later enroll in the Plan under one of the following circumstances:

- You or your eligible dependent were covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently ends
- You or your eligible dependent become eligible for a premium assistance subsidy under Medicaid or CHIP subsequent to the time you or your dependent were initially eligible

You or dependent must request enrollment in the Plan within 60 days after:

- Coverage under Medicaid or CHIP ends; or
- Your eligibility for a premium assistance subsidy under Medicaid or CHIP is determined.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan Administrator will immediately enroll an alternate recipient who is the subject of a Qualified Medical Child Support Order (QMCSO), if the individual is not already covered by the Plan as an eligible dependent.

Upon receiving a Medical Child Support Order, the Plan Administrator will, as soon as administratively possible, notify in writing (at the address included in the order) the covered person and each alternate recipient covered by the order of the Plan's:

- Receipt of the order
- Procedures for determining whether the order qualifies as a QMCSO

- The administrative determination whether the order is a QMCSO

The Plan 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).

NATIONAL MEDICAL SUPPORT NOTICE

Upon receiving a National Medical Support Notice, the Plan Administrator will:

- Notify the state agency issuing the notice whether coverage of the child is available under the terms of the Plan and, if so:
    - Whether the child is covered under the Plan; and
    - 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 begin the coverage; and
- 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 begin coverage.

To give effect to this requirement, the Plan Administrator will:

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 on the earliest to occur of the following dates:

- On the last day of the month in which the employee ceases to be eligible for coverage under the Plan
- 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
- 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
- On the date of termination of the Plan.

THE END OF YOUR BENEFITS

If you quit your job or your employment is terminated for another reason, your coverage will end on the last day of the last month that you were eligible for benefits.

WHEN DEPENDENT ELIGIBILITY ENDS

For dependents, coverage will end:

- On the last day of the month in which he or she ceases to be eligible for coverage under the Plan as a dependent
- For dependents, on the date of termination of dependent coverage under the Plan

You must immediately notify the Plan Administrator when an enrolled dependent is no longer eligible to be enrolled in the Plan.

If notice is not provided, the Plan Administrator, 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.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Plan Administrator will at all times comply with family or medical leave of absence in accordance 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.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

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 Open 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.

BENEFITS OVERVIEW

Preferred Provider Organizations (PPOs)

You'll receive the best benefit coverage when you obtain covered services from a Preferred Provider Organization (PPO) Provider. Here's why:

1. The Plan has negotiated discounts with PPO Providers.
2. This discounted fee is the allowable charge on which the Plan bases the percent you pay and the Plan pays.
3. PPO Providers cannot balance bill you for more than the allowable charge for covered services, so you won't have to pay excess charges.

When you choose a non-Preferred (non-PPO) Provider or an out-of-area provider, your benefits and out-of-pocket requirements vary.

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.

(For dialysis claims, PPO provisions may not apply. Please see the Outpatient Dialysis Treatment provisions for more information.)

PPO PROVIDERS

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.

- Mat-Su Regional Medical Center is the PPO hospital in the Mat-Su Borough.
- Aetna is the nationwide PPO network for the Plan, for all services. You can access a list of PPO providers at www.aetna.com/docfind. Log in, or select the Aetna Choice POS II (Open Access) network.

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

HOSPITAL CHOICE

You may choose any hospital; however, when you choose a PPO facility, you'll save money because the PPO charges a discounted fee and the Plan pays a higher percentage of the charges. If you choose a non-PPO facility for non-emergency care, the Plan pays a lower percentage of allowable charges.

DOCTORS

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.

YOUR CHOICE OF DOCTORS

You may choose any doctor; however, when you choose a PPO provider, you'll save money because the PPO provider charges a discounted fee and you are not responsible for the amount above the allowable charge.

NON-PPO PROVIDERS

When you use a Non-PPO provider, allowable charges will be paid at the Usual, Customary and Reasonable (UCR) 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

- If services are not available at a PPO facility.

PARTICIPANTS 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).

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.

Utilization Review 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 has confirmed that your services are Medically Necessary. Payment of benefits is based on the provisions of this Plan and your eligibility for coverage at the time the expense is incurred.

Precertification

The following is an explanation of the services that require precertification.

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.

SURGERY REQUIRES PRECERTIFICATION

If your doctor schedules you for surgery, it is your responsibility to obtain precertification as soon as possible prior to the scheduled surgery. Your doctor may initiate the precertification, but you are responsible for making sure the procedure or admission is certified.

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 if you have a serious condition that may jeopardize your 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.

IN CASE OF EMERGENCY

If you experience a medical emergency, you may go to the closest facility. If you are hospitalized as a result of the emergency notify Medical Rehabilitation Consultants Hospital within two business days.

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

Case Management

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.

CASE MANAGEMENT

Case Management is an optional, free service that can help patients and their families make the most of their benefits by helping to reduce costs and improve outcomes by using evidence-based decision support tools.

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.

MEDICAL BENEFITS

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	Calendar year deductible waived $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	Same as any other condition
Outpatient dialysis treatment	80% of the Usual and Reasonable charge See Outpatient Dialysis Treatment section
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

MEDICAL BENEFITS	
	80% out-of-area facility 50% non- PPO facility
Substance abuse treatment	Same as any other condition
Surgery using the BridgeHealth program (including travel expenses)	100%, not subject to the deductible. See BridgeHealth Medical Surgery Benefit for travel benefits.
Teladoc services	100%, not subject to the deductible
Transplant-related travel and lodging	80%, up to $50 per night, $10,000 per transplant period
All other travel	80%, up to $600 for transportation expense 80%, up to $150 per day for lodging Annual maximum of 7 days lodging
All other covered services	80%

DEDUCTIBLES

A deductible is the 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.

FOR CERTAIN SERVICES, THE DEDUCTIBLE IS WAIVED

For most covered services, you must pay the annual deductible before the Plan pays benefits. However, you do not need to pay the deductible before the Plan pays for preventive care services, Teladoc and BridgeHealth surgery.

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 (UCR) expenses incurred by or on behalf of a covered person for the hospital or other medical services listed below which are:

- Ordered by a physician
- Medically Necessary for the treatment of the illness or injury
- 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:

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.

Ambulance. Charges for transportation by professional ambulance, including approved available air ambulance, to a local hospital or transfer to the nearest facility having the capability to treat the condition. **Non-**

emergency ambulance services must be pre-certified.

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

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

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

BridgeHealth Medical Surgery Benefit. The BridgeHealth Surgery Benefit Management Program provides assistance to you and your covered dependents when a covered non-emergency surgery has been recommended and this Plan is your primary Plan.

100% COVERAGE FOR BRIDGE HEALTH SURGERY

If you use BridgeHealth for surgery:

- Your deductible is waived
- Benefits are reimbursed at 100% of allowable charges
- First class* airfare and lodging are covered for you and a companion.

*If the cost of the surgery and associated travel expenses through Bridge Health are expected to cost less than the cost of obtaining surgery locally, the plan will provide coach class travel instead of first class, unless first class travel is medically necessary.

You should contact BridgeHealth for information about the program if you or your dependents have planned major surgeries such as:

- Hip surgery
- Knee surgery
- Shoulder surgery
- Back surgery
- Heart surgery
- Women's health surgery
- General surgery

When a BridgeHealth surgical provider is elected, you will be assigned a care coordinator who will:

- Assist with requesting medical records for BridgeHealth surgery provider review
- Assist with selecting a BridgeHealth in-network provider
- Schedule surgery and provide pre-operative information
- Assist with applicable travel and lodging accommodations

Upon acceptance of your case, the following enhanced Plan provisions will apply when you utilize BridgeHealth network providers:

- Deductible is waived
- Benefits are reimbursed at 100% of allowable charges

Travel expenses are covered when a BridgeHealth Provider is not available within 100 miles from member's home and if the travel and lodging is arranged by a BridgeHealth Care Coordinator. The Plan covers expenses for travel and lodging for the patient and one companion as follows:

- Transportation for the patient and one companion who is traveling on the same day(s) to and/or from the site of treatment for a surgical episode of care which typically includes a pre-operative evaluation, the surgical procedure and necessary post-operative follow-up. Reasonable transportation expenses include:
    - First class airfare*
    - Mileage reimbursement at the IRS medical rate for the most direct route between the patient's home and the BridgeHealth designated facility
- Lodging: One-room accommodation at a BridgeHealth-approved hotel for the surgical episode
- Incidental Expense Benefit: Provides $50 per day to cover incidental expenses for the patient while not admitted to the hospital and $50 per day for one companion. Incidental expense benefits are limited to the surgical episode days.
- *If the cost of the surgery and associated travel expenses through Bridge Health are expected to cost less than the cost of obtaining surgery locally, the plan will provide coach class travel instead of first class, unless first class travel is medically necessary.

Chemotherapy. Charges for chemotherapy and radiation therapy.

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.

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, implants, and Intrauterine Devices (IUDs). Covered expenses include consultations, exams, procedures and other related medical services and supplies.

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.

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 and 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.

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.

Durable Medical Equipment (DME). 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:

- Repairs
- Replacements for equipment still under warranty
- The rental or purchase of items which do not fully meet the definition of "durable medical equipment"

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.

Hemodialysis. Charges for hemodialysis.

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

- Registered nurses or licensed practical nurses
- Certified home health aides under the direct supervision of a registered nurse
- Registered therapist performing physical, occupational or speech therapy
- Physician calls in the home
- 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.

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:

- Room and board for confinement in a hospice
- 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

- 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
- Physician services and nursing care by a registered nurse, licensed practical nurse or a licensed vocational nurse
- Home health aide services
- Home care furnished by a hospital or home health hare 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
- Medical social services by licensed or trained social workers, psychologists or counselors
- Nutrition services provided by a licensed dietitian
- Respite care
- 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:
    - 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
    - Charges for such services are incurred by the covered persons within 6 months of the terminally ill person's death.

Hospital. Charges made by a hospital for:

- Inpatient treatment
    - Daily semi-private room and board charges
    - Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) room and board charges
    - General nursing services
    - Medically Necessary services and supplies furnished by the hospital, other than room and board
- Outpatient treatment
    - Emergency room
    - Treatment for chronic conditions
    - Physical therapy treatments
    - Hemodialysis
    - X-ray, laboratory and linear therapy

EMERGENCY ROOM COVERAGE

The Plan does not provide coverage for non-emergency services received at a hospital emergency room. Refer to "Emergency" in the Definitions section. For non-emergency care, go to your doctor's office or urgent care clinic, or contact Teladoc.

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.

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.

Mastectomy. Charges in connection with a mastectomy will include the following, in a manner determined in consultation with the attending physician and the patient:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and physical complications from all stages of mastectomy, including lymphedemas

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).

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:

- Hospital routine care for a newborn during the child's initial hospital confinement at birth
- The following physician services for well-baby care during the newborn's initial hospital confinement at birth:
    - The initial newborn examination and a second examination performed prior to discharge from the hospital
    - 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.

NEWBORN COVERAGE

You must enroll the newborn in the Plan during the first 31-day period following birth in order to obtain ongoing health coverage past the first 31-days of life.

Nursing Services. Charges for services of a registered nurse or licensed practical nurse.

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.

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.

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.

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

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

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.

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.

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.

Prosthetics. Charges for the initial placement of prosthetic devices.

Radiation Therapy. Charges for radiation therapy and treatment.

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

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:

- 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;
- 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
- 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.

Speech Therapy. Charges for speech therapy, by a physician or qualified speech therapist, when needed due to an illness or injury or due to surgery performed as the result of an 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.

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

- Multiple procedures adding significant time or complexity will be allowed at:
  - 100% (full Usual, Customary and Reasonable value) for the first or major procedure
  - 50% for the second and subsequent procedures
- 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.
- 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.

Telemedicine. The Plan will cover telemedicine visits by a covered provider acting within the scope of the provider's license. These visits are subject to deductibles, coinsurance and all other plan provisions.

In addition, the Plan will cover Teladoc© phone or video consultations with a physician. Teladoc 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.

Taking care of your mental health is an important part of your overall well-being. You may also utilize Teladoc for virtual Behavioral Health visits with a doctor or therapist. Adults 18 and older can get care for anxiety, depression, grief, family
issues, and more **at no cost to you**.

Scheduling a video visit with a therapist is easy and convenient. You can make an appointment seven days a week from 7 a.m. to 9 p.m. local time. Appointments are confirmed within 72 hours.

TELADOC

You have 24-hour access to Teladoc physicians at no cost to you.

You may make appointments with Behavioral Health providers 7 days a week, from 7am - 9 pm.

Call 800-TEL-ADOC or visit www.teladoc.com

TMJ Syndrome. Charges in connection with temporomandibular joint (TMJ) syndrome or dysfunction.

Travel. The Plan will cover travel benefits based on the following:

- Travel must be pre-certified by the Plan Administrator; and
- 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,
- 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.

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

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 preauthorization 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.

PRECERTIFY TRANSPLANTS

As a surgical procedure, transplants must be precertified by contacting Medical Rehabilitation Consultants as soon as possible after the need for a transplant is determined

The benefits under this Plan are available only when the transplant recipient is a covered person.

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart
- Lung
- Heart/Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be more than one transplant occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant)
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant)
- Re-transplant after 180 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process
- More than one transplant when not performed as part of a planned tandem or

sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The network level of benefits is paid only for a treatment received at a facility designated by the Plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services.

The Plan covers:

- Charges made by a physician or transplant team
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another Plan or program
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services
- Charges for activating the donor search process with national registries
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative; these are your biological parents, siblings or children
- Inpatient and outpatient expenses directly related to a transplant

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; or upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

- **Pre-transplant evaluation/screening**: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program
- **Pre-transplant/candidacy screening**: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members
- **Transplant event**: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement
- **Follow-up care**: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an IOE facility will be considered network care expenses.

Important reminder. To ensure coverage, all transplant procedures need to be pre-certified. Medical Rehabilitation Consultants will work with Aetna for precertification of transplants in the IOE network.

Network of Transplant Specialist Facilities. Through the IOE network, you will have access to a provider network that specializes in transplants. Benefits may vary if an IOE facility or non-IOE or out-of-network provider is used. In addition, some expenses are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. Each facility in the IOE network has been selected to perform only certain types of transplants, based

on quality of care and successful clinical outcomes.

Limitations. Unless specified above, not covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence
- Services that are covered under any other part of this Plan
- Services and supplies furnished to a donor when the recipient is not covered under this Plan
- Home infusion therapy after the transplant occurrence
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without the expectation of transplantation within 12 months of harvesting for an existing illness
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Refer to the Schedule of Benefits for details about transplant expense maximums, if applicable.

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.

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:
  - Significant inflation of the prices charged to covered persons by dialysis providers
  - The use of revenues from claims paid on behalf of covered persons to subsidize reduced prices to other types of payers as incentives
  - The specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers
- The fiduciary obligation to preserve Plan assets against charges which
  - Exceed reasonable value due to factors not beneficial to covered persons, such as market concentration and discrimination in charges
  - 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:

- 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.
- 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:

- 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.
- 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.
- **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.
- **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.
- **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.
- 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

- Such payment shall be for the full amount due for the provision of services and supplies to a covered person
- 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:

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

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.

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.

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.

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

Charges incurred in connection with custodial care.

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.

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.

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.

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.

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.

Charges for experimental treatment.

Charges for routine foot care.

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.

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

Charges for hospital admissions when such confinement is for

- Physiotherapy, hydrotherapy, convalescent or rest care
- Any routine physical examinations or tests not connected with the actual Illness or injury
- Treatment of a non-covered illness or injury

- 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

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.

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.

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.

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.

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

Charges to the extent they exceed the Medicare limiting charge, for covered persons for whom this Plan pays its benefits secondary to Medicare.

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).

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

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.

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

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.

Charges for orthotic appliances.

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.

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.

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.

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.

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.

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.

Charges for biofeedback.

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

Charges in connection with speech therapy, except as specifically included.

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.

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.

Charges incurred for travel, except as specifically included.

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.

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

Schedule of Benefits

PRESCRIPTION DRUG BENEFITS	
Retail Copays (per 30 day supply)	
Generic	$10
Preferred Brand	$25
Non-Preferred Brand	$45
Mail Order Copays (up to a 90 day supply)	
Generic	$20
Preferred Brand	$50
Non-Preferred Brand	$90
Pre-authorization is required for specialty drugs and specialty medications are limited to a 30-day supply.	

Participating Pharmacies

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.

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. 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.

CHOOSE GENERICS WHEN POSSIBLE

You'll save money when you choose a generic medication instead of a brand-name drug. Ask your doctor or pharmacist about generic drug options.

MAIL ORDER OPTION

An option is also available to order maintenance drugs through mail order.

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.

USE THE MAIL ORDER OPTION

You'll save money and enjoy convenient home delivery when you purchase medication you take on a regular basis through CVS/Caremark mail-order.

Covered Expenses

The following are covered under the Plan:

- All drugs prescribed by a physician that require a prescription (including contraceptives) either by federal or state law, except the drugs excluded below
- All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity
  - Compound medications in excess of $300 require prior authorization and are limited to one fill per 25 days
- Insulin, insulin syringes and needles, and insulin-related chemical strips, when prescribed by a physician for the treatment of diabetes
- Tobacco cessation products

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.

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.

Formulary

The formulary is a list of covered drugs that serves as a guide for you and your doctor within select drug classed. The formulary is managed by CVS/Caremark. Non-formulary drugs are not included on the drug list and may be considered non-preferred or may be excluded from coverage. You may be responsible for up to the full cost of a non-formulary drug. The formulary is subject to change. An appeals process is available to accommodate medical necessity circumstances.

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 CVS/Caremark 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.

Limitations

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

- 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 Dispense as 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.
- Tretinoin agents used in the treatment of acne and/or for cosmetic purposes (ex. Retin-A) are covered through age 25 only
- Refills only up to the number of times specified by a physician
- Refills up to one year from the date of order by a physician
- With respect to the retail network pharmacy option and any specialty medication, any one prescription is limited to a 30-day supply
- 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:

- Devices or appliances, support garments and other non-medicinal substances, regardless of their intended use, except as specifically included.
- 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.
- Any refill dispensed after one year from the order of the physician or the maximum time allowed by law if less than one year.
- Drugs labeled "caution - limited by federal law to investigational use," or experimental treatment drugs, even though a charge is made to the individual.
- Prescriptions which an eligible person is entitled to receive without charge from any governmental program.
- Charges for the administration or injection of any medication, other than vaccines.
- Medication which is taken or administered, in whole or part, while the person is confined in a hospital or other health care facility

- Prescriptions which an eligible person is entitled to receive without charge under any workers' compensation or similar law.
- Anorexiants (weight-loss drugs) and anti-obesity drugs; fertility drugs; erectile dysfunction drugs; nutritional supplements; and rogaine.
- Replacement of lost or stolen medication.
- Over-the-counter drugs, except for insulin, even if prescribed.
- Medications which are considered excluded on the Caremark Advance Control Formulary.

COST EFFECTIVENESS PLAN DESIGN PROGRAM

This program only applies to new medications on the market or new indications for existing medications, starting January 1, 2020.

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.

FOR MORE INFORMATION

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

DENTAL BENEFITS

Schedule of Benefits

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)	
Type I: Diagnostic and Preventive	100%, not subject to the deductible
Type II: Restorative	80%
Type III: Reconstructive	50%

DEDUCTIBLE
After you pay the annual Dental Plan deductible (except for Type I services), the Dental Plan pays a percentage of the Plan's allowed amount for charges for covered expenses, up to the annual benefit maximum.

Covered Services

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

TYPE I: DIAGNOSTIC AND PREVENTIVE SERVICES

- 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.
- Diagnostic services, including diagnostic X-rays, as follows:
  - Full mouth series including bitewings, if needed, and panoramic film
  - Bitewing films
  - Vertical bitewing x-rays
- Topical fluoride application for covered persons under age 20, limited to two treatments in any 12- month period.
- Prophylaxis, limited to two in any 12-month period.
- Sealants for covered persons under age 14.
- 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

- Emergency palliative treatment
- Diagnostic X-rays, including:
  - Intraoral periapical or occlusal x-rays- single films
  - Extraoral superior or inferior maxillary film
- Extractions
- Amalgam, silicate, acrylic, synthetic, porcelain and composite filling restoration to restore diseased or accidentally broken teeth.
- Oral surgery performed on the teeth or gums.
- Transplantation of tooth or tooth bud.
- General anesthetics and IV sedation administered in the dentist's office in connection with covered oral or dental surgery.
- Treatment of periodontal and other diseases of the gums and tissue of the mouth.
- Injection of antibiotic drugs by an attending dentist.
- Endodontics, including root canal therapy.
- Crowns (when tooth cannot be restored with a filling material):
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
- Repair or re-cementing of crowns, inlays, and bridgework, and repair of dentures.

TYPE III: RECONSTRUCTIVE SERVICES

- 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.

- Labial veneers, resin and porcelain laminate.
- Initial installation of fixed bridgework, including inlays and crowns as abutments.
- Initial installation of partial or full removable dentures, including precision attachments and any adjustments during the six-month period following installation.
- 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.
- Relining or rebasing of dentures more than 6 months after initial placement or replacement of dentures.
- 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:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture was installed.
- The existing denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement.
- 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 Administrator prior to the commencement of the course of treatment.

GETTING AN ESTIMATE

While it's not required by the Plan, asking your dentist for a Dental Treatment Plan will let you know your Dental Plan benefits and an estimate of your out-of-pocket costs.

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 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.

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:

- Charges for cosmetic procedures, including, but not limited to, personalization or characterization of complete or partial denture restoration.
- Charges for oral hygiene instructions, plaque control or dietary planning.
- Charges for replacement of dentures and removable or fixed prosthesis due to theft, misplacement or loss.
- 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.
- Charges for space maintainers, except as specifically included.

- Charges for general anesthesia and intravenous sedation in connection with a non-covered service.
- 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.
- Charges for any services or supplies which are eligible for coverage under any other part of the Plan.
- 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.
- 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:
    - For an appliance or modification of an appliance, the date the impression was taken
    - For crowns, bridge work or gold restorations, the date the tooth was seated
    - 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.
- Charges for temporary restorations.
- Dental care that does not have ADA endorsement.
- Customized dental procedures.
- 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

Schedule of Benefits

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	

The Plan provides benefits for vision services, according to the frequency shown in the Schedule of Benefits. The vision benefits are administered by Vision Service Plan (VSP).

Provider Selection

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.

CHOOSING A PROVIDER
You may choose any licensed vision care provider to obtain services and purchase frames and lenses; but your out-of-pocket costs will be lower when you choose a VSP Provider.

Covered Services

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
- 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

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)

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.

OTHER COVERAGE

If you have other coverage, both plans together may pay up to 100% of covered services that you receive. Notify the Plan Administrator of other coverage you, your spouse or your dependents may have.

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 Plan 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:

- 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:
  - Hospital indemnity benefits
  - Hospital reimbursement-type plans
- Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans
- Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision
- A licensed Health Maintenance Organization (HMO)
- Any coverage for students that is sponsored by, or provided through a school or other educational institution
- Any coverage under a government program, and any coverage required or provided by any statute
- Group automobile insurance
- Individual automobile insurance coverage on an automobile leased or owned by the employer

- Individual automobile insurance coverage based upon the principles of “no fault” coverage
- 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
- Labor/management trustees, union welfare, employer organization or employee benefit organization plans
- Individual homeowner’s insurance coverage
- Individual renter’s insurance coverage
- 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:

- If a plan contains no provision for coordination of benefits or states that its coverage is primary, then it pays before all other plans.
- 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.
- 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:
  - 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.
  - 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.
- A “no fault” automobile policy not described in the first bullet above will be primary.
- If the order described 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:

- To obtain or share information with an insurance company or other organization regarding coordination of benefits without the claimant’s consent.
- To require that the claimant provide the Plan with information on such other plans so that this provision may be implemented.
- 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.
- 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

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.

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.

MEDICARE NOTICE
If you are eligible for Medicare, your benefits will be reduced by Medicare Part A & B benefits, whether or not you enroll in Medicare.

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.

CLAIMS AND APPEALS

Filing 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 the APEA-AFT Health Benefits Trust.

SHOW YOUR ID CARD TO YOUR PROVIDERS

Present your Health Plan ID card to your provider at the time of service. This helps your provider submit your claims efficiently and quickly.

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 health care 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.

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.

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.

FILING POST-SERVICE CLAIMS

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:

- The date of service
- The name, address, telephone number and tax identification number of the provider of the services or supplies
- The place where the services were rendered
- The diagnosis and procedure codes
- The amount of charges (including PPO network repricing information)
- The name of the Plan
- The name of the covered employee
- The name of the patient

WHEN HEALTH CLAIMS MUST BE FILED

Health claims must be filed with the Plan Administrator within 365 days of the date charges for the service was 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. You must provide all information requested to complete the claim or review the claim prior to the deadline for timely filing.

Appeal Rights and Procedures

When the Plan makes an adverse benefit determination, the Plan shall provide a covered person with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the Summary Plan Description upon which a denial is based
- Specific reason(s) for a denial
- A description of any additional information necessary for the covered person to perfect the claim and an explanation of why such information is necessary
- 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
- 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)
- 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)
- 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.

MAKING AN APPEAL

You have the right to appeal denied benefit claims, but you must follow the procedures described in this Summary Plan Description and meet all deadlines.

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:

- 180 days following the notification of an adverse benefit determination within which to appeal the determination
- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits
- 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
- 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
- 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
- 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
- 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 Plan 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 & Pension Administration Service, Inc.
C/o Appeals
PO Box 34203
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:

- The name of the covered person
- The covered person's alternative Plan identification number or Social Security number
- All facts or theories supporting the claim for benefits
- 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
- 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:

- Information to identify the claim, including, the date of service, the health care provider, the claim amount (if applicable).
- Specific reasons for the denial.
- Specific reference to pertinent Plan provision(s) on which the denial is based.
- 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.
- 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.
- 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.
- 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.
- A description of the Plan's internal review and external review procedure and the applicable time limits.
- 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.
- 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 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 Trustees 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 Plan Administrator following the meeting, with a written decision to follow as soon as practical, but not more than 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 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 the level 1 – internal review section above.

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

- 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
- 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 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 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 Plan 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.

CONTINUATION OF COVERAGE UNDER COBRA

Overview of COBRA

Your 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.

OPTIONS BESIDES COBRA

You may be eligible for Medicaid or other group health Plan coverage (such as through a spouse's Plan). Generally, you must enroll within 30 days of losing your benefit eligibility under this Plan.

Or, you may be eligible to buy an individual Plan through the Health Insurance Marketplace, where you may qualify for lower costs on your monthly premiums and have lower out-of-pocket costs. Learn about your options at www.healthcare.gov.

Qualifying Events

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 below.

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.

WHAT COBRA COSTS

You pay the full monthly rate for yourself and any dependents you enroll. Contact the Plan Administrator to request the current rates.

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

- Your hours of employment are reduced
- 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 one of these 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)
- 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 one of these 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
- The child stops being eligible for coverage under the Plan as a "dependent child"

The Plan Administrator 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 Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment
- Death of the employee
- 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 Administrator within 60 days after the qualifying event occurs.

Once the Plan Administrator 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.

HOW TO GET COBRA STARTED

To begin COBRA coverage, contact the Plan Administrator to confirm you qualify for coverage, request rates and get enrollment instructions.

You must enroll in COBRA within 60 days of a qualifying event or the date of the COBRA notice, whichever is later.

When Coverage Begins and Ends

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

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator 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.

HOW LONG COBRA CONTINUES

COBRA coverage is intended to provide temporary benefit coverage. You may continue to pay for coverage for up to 18 months. In certain circumstances, COBRA may be continued up to 36 months.

SECOND QUALIFYING EVENT EXTENSION

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 Administrator 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:

- Becomes entitled to Medicare benefits (under Part A, Part B, or both),
- Gets divorced or legally separated;
- Dies
- 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.

NOTICE OF PRIVACY PRACTICES

The APEA-AFT Health & Welfare Trust Fund understands that medical information about you and your health is personal, and we are committed to protecting your privacy by protecting that information. This notice describes the medical information practices of the group health Plans offered through the Trust and those of any third party that assists in the administration of the Plans. We (that is, the Trust and the Plans it offers) keep a record of all health care claims paid under the Plans, as well as enrollment and other demographic information and records. This notice applies to all of the medical records we maintain, as well as other personal information that the Trust and Plans have obtained about you and your eligible dependents. 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 you with information about how the Trust and Plans may use or disclose medical information that is considered PHI and what your rights are with respect to such information. This Notice also applies to any organization that assists in the administration of the Plans. Your personal doctor 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.

PROTECTING YOUR PRIVACY

HIPAA protects your medical records and other personal health information with clear boundaries on the use and release of health records and appropriate safeguards to protect the privacy of health information.

We are required by law to:

- ensure that medical information that identifies you is kept confidential;
- give you this notice of the legal duties and privacy practices related to medical information that we maintain about you; and
- follow the terms of the notice that is currently in effect.

HOW THE TRUST AND PLANS MAY USE AND DISCLOSE MEDICAL INFORMATION

The following categories describe methods that the Trust and Plans use and disclose medical information. All of the methods we use 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** – We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services that you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may communicate with your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We also may share your 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, we may share your medical information to aid in coordination of benefits with another group health plan.
- **For Health Care Operations** – We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, your medical information may be used when we conduct 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** – We will disclose medical information about you when we are required to do so by federal, state, or local law. For instance, we 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** – We may use and disclose medical information about you 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 you are an organ or tissue donor, we may release medical information about you 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 you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation** – We may release medical information about you to workers' compensation or similar programs.
- **Public Health Risks –** Medical information about you 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 you have been the victim of abuse, neglect, or domestic violence.

  We will make these disclosures only if you agree or if they are required or authorized by law.

  - **Health Oversight Activities** – We 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 you are involved in a lawsuit or dispute, we may disclose medical information about you 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 you about the request or to obtain an order protecting the information.
- **Law Enforcement** – We 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** – We may release medical information about you 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** – We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Inmates** – If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may release medical information about you

to the correctional institution or the law enforcement official, if necessary for (1) the institution to provide you with health care, (2) to protect your health or safety or the health or safety of others, or (3) for the safety and security of the correctional institution.

The Trust or Plans 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 Trust or Plans offered through the Trust will be made only with your written permission. The Trust and Plans are specifically prohibited from using or disclosing psychotherapy notes without our prior authorization. The Trust and Plans further cannot use your medical records for marketing purposes, sell your medical records, disclose your 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 you provide us with permission to disclose medical information about you, you may revoke that permission at any time, in writing. We will require that you complete an Authorization for Release of Protected Health Information and return it to the Trust Administration Office before such information will be provided to a third party. You have the right also to revoke the Authorization, but such revocation must also be in writing and directed to the Trust Administrative Office. If you revoke your permission to disclose medical information, we will no longer use or disclose medical information about you for the reasons covered by your written authorization after the date of receipt of the revocation.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information that we maintain about you:

- **Right to Inspect and Copy Your Medical Records.** You may inspect and copy medical information that we may use to make decisions about your Plan benefits. To inspect and copy such information, you must submit your request in writing to the Trust Administrator at PO Box 34203 Seattle, WA 98124-1203. If you request a copy of the information, you may be charged a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. In very limited circumstances, your request to inspect or copy your records may be denied. If you are denied access to your medical information, you may request that the denial be reviewed by the Board of Trustees.
- **Right to Amend Your Medical Records.** If you feel that medical information maintained by us is incorrect or incomplete, you may request that the information be amended. To request an amendment, your request must be made in writing to the Trust Administrator at PO Box 34203 Seattle, WA 98124-1203. Also, you must provide a reason to support your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask to amend information (1) that is not part of the medical information kept by us 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 you would be permitted to inspect or copy; or (4) is accurate and complete.
- **Right to an Accounting of Disclosures.** You have 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, you must submit your request in writing to the Trust Administrator PO Box 34203 Seattle, WA 98124-1203. Your request must state the time period for which you require a list or accounting of disclosures, but the period may not exceed six years. Your request should indicate in what form you want the accounting (paper or electronic). The first list that you request within a 12-month period will be provided without charge. However, we may charge you for

the cost of providing additional requests. You will be notified of the approximate cost involved prior to providing you with a response to additional requests, and you may choose to withdraw or modify your request at that time, before costs are assessed.

- **Right to Request Restrictions.** You may request a restriction or limitation of the medical information we use or disclose about you for treatment, payment, or health care operations. You also may request a limit on the medical information that is disclosed about you to someone who is involved in your care or the payment for your care, such as a family member or caregiver. For instance, you may request that we not disclose information about a particular medical treatment. We are *not* required to agree to your request. To request restrictions, you must make your request in writing to the Trust Administrator at PO Box 34203 Seattle, WA 98124-1203. The request must state (1) what information you want to limit; (2) whether you want to limit our use or disclosure or both; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You may request that we communicate with you about medical matters in a certain way or at a certain location, such as only at your home address or only by mail. To request confidential communications, you must make your request in writing to the Trust Administrator at PO Box 34203 Seattle, WA 98124-1203. We will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

- **Right to a Paper Copy of this Notice.** You may request a paper copy of this notice. You may also ask that you be given a copy of this notice at any time. Even if you have agreed to receive notices and communications electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Trust Administrator at PO Box 34203 Seattle, WA 98124-1203, Telephone Toll Free: (800) 478-9991, Local: (907) 789-0182.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We also reserve the right to make the revised or changed notice effective for medical information that we already have about you as well as any information we receive in the future. A current copy of this notice will be posted on the Trust website and will contain the effective date of the notice clearly posted at the top of the first page.

COMPLAINTS

If you believe your privacy rights have been violated, you 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 Trust or Plans, contact the Trust Administrator at PO Box 34203 Seattle, WA 98124-1203. All complaints must be submitted in writing.

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.

Standard 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.

PROHIBITION OF ASSIGNMENT OF RIGHTS

All rights to benefits under this Plan are personal and available only to you. They may not be transferred to anyone else. Benefits or rights of members of this Plan are not assignable or subject to garnishment, alienation, or attachment by creditors.

A covered person is prohibited from assigning his/her right to sue to recover benefits under the Plan, to enforce rights due under the Plan to appeal a denial of benefits, or any other causes of actions which he/she may have against the Plan or its fiduciaries. Providers are not beneficiaries of the Plan under any circumstance, but may receive payment of benefits under an assignment of benefits described below.

ASSIGNMENT OF BENEFITS

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 of benefits 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 payment 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:

- The hospital must agree to submit itemized bills, chart notes and other medical records that are necessary and appropriate for such an audit
- The hospital must agree to fully cooperate with the Plan's designated auditor
- The hospital must comply with the audit and the Plan's designated auditor free of charge

The covered person responsibilities:

- The covered person will be responsible for any amount owed to the hospital due to its failure to comply with this provision.
- 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:

- Benefits may not be assigned to a non-U.S. provider
- The covered person is responsible for making all payments to non-U.S. providers, and submitting receipts to the Plan for reimbursement
- Benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date
- The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements
- 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.

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.
    - 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 lawsuit 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 is 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 the right 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

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.

CLERICAL ERRORS

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:

- 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.
- Attempting to file a claim for a covered person for services which were not rendered or drugs or other items which were not provided.
- Providing false or misleading information in connection with enrollment in the Plan.
- 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.

WORKERS COMP

Workers' compensation insurance generally covers the expenses that come with a work-related illness or injury. Ask your doctor to file the appropriate documentation if you have a work-related illness or injury.

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:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise.
- No final determination is made that the injury or illness was sustained in the course of or resulted from your employment.
- 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.
- 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 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** 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 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 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 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:

- The last day of the one-year period
- The day the Plan benefit maximum applicable to the covered person becomes payable
- The day the covered person ceases to be covered for benefits under this Plan

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 shall mean a facility that meets the following requirements:

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

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

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.

Plan Administrator shall mean WPAS, Inc.

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

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:

- It is due to a different or unrelated injury or illness causing the prior confinement
- It is separated by 30 consecutive days when the covered person is not confined

Convalescent nursing facility shall mean a lawfully operated institution or that part of such an institution that meets all of the following conditions:

- 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
- Its services are provided for compensation from its patients and under the full-time supervision of a physician or registered nurse
- It maintains a complete medical record on each patient
- It has an effective Utilization Review Plan
- It is not, other than incidentally, a place for rest, the aged, custodial or educational care.

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 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:

- The confinement must have been for a period of not less than three consecutive days
- 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 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 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 shall mean a covered employee and his or her covered dependents who are eligible for benefits under the Plan.

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 person in 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 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 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 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:

- Itemizes the dental procedures required for the necessary care of the individual

- Shows the charges for each procedure
- Is accompanied by any appropriate diagnostic material as may be required by the Plan

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

Dependent shall mean:

- 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.
- The employee's child who is less than 26 years of age, including:
  - Natural children and legally adopted children
  - Stepchildren, 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:

- He or she is mentally or physically handicapped
- He or she is incapable of self-sustaining employment
- He or she is dependent on the covered employee for at least 50% of his or her support and maintenance
- 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:

- 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.
- Any person on active military duty.

Durable medical equipment shall mean equipment that is:

- Able to withstand repeated use
- Primarily and customarily used to serve a medical purpose
- Not generally useful for a person in the absence of illness or injury

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 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 shall mean a covered employee and his or her covered dependents.

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

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.

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.

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

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:

- It is primarily engaged in providing skilled nursing and other therapeutic services and is duly licensed, if required, by the appropriate licensing authority
- 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
- It maintains a complete medical record on each individual
- It has a full-time administrator

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 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 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 shall mean an agency or organization that meets all of the following tests:

- Has hospice care available 24 hours a day
- Is licensed as such by the jurisdiction it is in
- Provides:
  - Skilled nursing services
  - Medical social services
  - Psychological and dietary counseling
- Provides or arranges for other services which will include:
  - Services of a physician
  - Physical or occupational therapy
  - Part-time or home health aide services consisting of primarily caring for a terminally ill family member
  - Inpatient care in a facility when needed for pain control and other acute and chronic symptom management

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:

- Is established, equipped and operated mainly as a setting for providing inpatient hospice care to terminally ill persons
- Charges for the services and supplies it provides
- Is licensed as such by the jurisdiction it is in
- Keeps medical records on each patient
- 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
- 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
- Provides 24-hour-a-day skilled nursing services under the direction of registered nurses
- Has a full-time administrator
- Has personnel which includes at least
  - One physician
  - One registered nurse
  - One licensed or certified social worker (lsw/csw) employed by the agency
  - One pastoral or other counselor
- Has established policies governing the provisions of hospice care
- Assesses the patient's medical and social needs and develops a hospice care program to meet those needs
- Permits all area medical personnel to utilize its services for their terminally ill patients
- Utilizes volunteers trained in providing services to terminally ill patients to meet their non-medical needs

Hospice care program shall mean a written Plan of hospice care, which:

- Is established by and periodically reviewed by:
  - A physician attending the covered person
  - Appropriate personnel of a hospice care agency
- Is designed to provide palliative and supportive care to terminally ill persons
- Includes an assessment of the medical and social needs, and a description of the care to be rendered to meet those needs

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

- It is engaged primarily in providing medical care and treatment to ill and injured persons on an inpatient basis at the patient's expense
- It is constituted, licensed and operated in accordance with the applicable laws of the jurisdiction in which it is located
- 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
- Such treatment is provided for compensation by and under the supervision of physicians with continuous 24-hour nursing services by registered nurses
- It qualifies as a hospital or a psychiatric hospital and is licensed by the appropriate state authority
- It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics or a nursing home

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 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 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 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 shall mean a section, ward or wing within a hospital, which is separated from other facilities, and:

- Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients
- Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use
- Provides constant observation and treatment by registered nurses or other highly trained hospital personnel

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 shall mean any health care treatment, service or supply determined by the Plan to meet each of these requirements:

- It is ordered by a physician for the diagnosis or treatment of an illness or injury
- 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
- 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 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 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 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 shall mean a registered nurse who is licensed as a midwife by the state in which the services are provided.

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 shall mean a licensed optometrist.

Oral surgery shall mean maxillofacial surgical procedures limited to:

- Excision of neoplasms including benign, malignant and pre-malignant lesions, tumors and cysts
- Incision and drainage of abscess
- Surgical procedures involving accessory sinuses, salivary glands and ducts
- Removal of impacted teeth

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

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

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

Plan sponsor shall mean APEA-AFT.

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

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

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 shall mean a licensed psychologist or psychological associate.

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

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 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:

- Its main purpose is to provide 24-hour-a-day accommodations and skilled nursing care for patients recovering from sickness or injury
- It is not used mainly as a place for the aged, drug addicts, alcoholics, the mentally ill, or a place for rest
- It is licensed by the appropriate state authority and/or approved by Medicare
- It is under the full-time supervision of a physician or registered graduate nurse
- The patient's plan of care is prescribed by a physician and updated at least every 30 days
- It has an agreement to have physician's services available when needed
- It maintains adequate medical records for all patients
- It has written transfer agreement with at least one hospital
- It is approved as such by Medicare

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 shall mean a condition, certified by a physician, to be primarily alcoholism or drug dependency.

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

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 shall mean the Uniformed Services Employment and Reemployment Rights Act, a Federal law, effective October 13, 1994.

Usual, Customary and Reasonable (UCR) 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
- 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 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.

GENERAL PLAN INFORMATION

Name of Plan: APEA-AFT Health and Welfare Trust Employee Benefit Plan

Plan Administrator: (Named Fiduciary)

> APEA-AFT Board of Trustees
> PO Box 34203
> Seattle, WA 98124-1203
> 800-331-6158

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

Plan Administrator: Welfare & Pension Administration Service, Inc.

> 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 and Welfare Trust