Teamsters Security Fund for Southern Nevada - Local 14
Non-Medicare Retiree Plan

Plan Document/Summary Plan Description

for

Eligible Non-Medicare Retirees and Dependents

describing the self-funded

Medical PPO Plan, Dental PPO Plan, Vision PPO Plan Benefits

Amended, restated and effective July 1, 2023

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Teamsters Security Fund for Southern Nevada – Local 14
Non-Medicare Retiree Plan

Dear Plan Participants:

This is the Plan Document and Summary Plan Description of the self-funded Non-Medicare Retiree Plan Benefits of the Teamsters Security Fund for Southern Nevada - Local 14 ("Plan"). This document describes the Medical PPO plan including prescription drugs, Dental PPO plan, and Vision PPO plan benefits. Plan Benefits are designed to help cover many of your expenses when you become sick or are injured.

The Plan has been adopted for the exclusive benefit of Participants (and their Covered Dependents) who are employed by certain employers who participate in this Fund.

This Plan is a "retiree only" plan that is not subject to many group health plan requirements under HIPAA and the Affordable Care Act.

Here are some important tips on using your Medical, Dental and Vision Benefits:

- ✓ The Medical Plan, Dental Plan and Vision Plan give you access to a network of Preferred PPO Providers. Preferred PPO Providers give a discount off their usual cost of services. Using Preferred PPO Providers will result in a substantial savings to you and to the Plan.

- ✓ Because PPO providers are added to or removed from the PPO network each month, it is a wise idea to check with the provider to see if they are still participating in the PPO network before you schedule an appointment or go get lab work or x-rays or other services. Don't rely on your Doctor or health provider to know your benefit plan.

- ✓ Certain services require pre-approval (also called precertification or prior authorization) before the service is performed. This is discussed in Article VII on Utilization Review and Case Management.

- ✓ Notify the Administrative Office of any address changes to ensure that you receive updated Plan, COBRA and self-pay information. Inform the Administrative Office of any changes in your Eligible Dependents (for example, marriage, divorce, child reaches the age of 26 years).

- ✓ Important and helpful contact information is listed on the Quick Reference Chart located in the front of this document.

As your Trustees, we make every effort to administer the Trust carefully. We make changes to your Plan as the Trust's financial condition changes. Eligibility provisions and Benefits may be increased or decreased from time to time. You will be notified if there are changes.

Sincerely,

Board of Trustees

ARTICLE I. INTRODUCTION

WHAT THIS DOCUMENT TELLS YOU

This Plan Document/Summary Plan Description describes the self-funded Medical, Dental and Vision Plan Benefits of the Teamsters Security Fund for Southern Nevada – Local 14 Non-Medicare Retiree Plan. The Plan described in this document is effective **July 1, 2023.**

- To determine if you are in a class of individuals who are eligible for Benefits under this Plan, refer to the Eligibility Article in this document. Coverage for eligible Dependents will be conditioned on you providing proof of Dependent status, satisfactory to the Plan.
- Note that receipt of this document does not guarantee eligibility for Plan benefits.

This document will help you understand and use the Benefits provided by the **Teamsters Security Fund for Southern Nevada - Local 14 Non-Medicare Retiree Plan**. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. Be sure to read the Exclusions Article and Definitions Article.

While recognizing the many Benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan.

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in Article II.

IMPORTANT INFORMATION

Teamsters Security Fund for Southern Nevada - Local 14 is committed to maintaining health care coverage for Non-Medicare Retirees and their family at an affordable cost; however, because future conditions cannot be predicted, the Plan Administrator (the Board of Trustees) reserves the right to amend or terminate coverages at any time and for any reason.

The benefits of this Plan are not vested. A vested right refers to a benefit that an individual has earned the right to receive and that cannot be forfeited.

As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

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

- The Medical PPO plan, Dental PPO plan, and Vision PPO plan benefits are self-funded with contributions from contributing employers, eligible Non-Medicare Retirees and COBRA Beneficiaries held in a Trust which is used to pay Plan Benefits. Third Party Administrators pay Benefits out of Trust assets.
- The life and accidental death and dismemberment insurance, and HMO Dental Plan Benefits are fully insured with insurance companies whose contact information is listed on the Quick Reference Chart in this document. These Benefits are described in other documents provided by the various insurance companies.

SUGGESTIONS FOR USING THIS DOCUMENT

This document provides detail about your Plan. We suggest that you pay particular attention to the following:

- Read through this **Introduction** and look at the **Table of Contents** that immediately precedes it. If you don't understand a term, look it up in the Definitions Article. The **Table of Contents** provides you with an outline of the Articles. The **Definitions** Article explains many technical, medical and legal terms that appear in the text.
- This document contains a **Quick Reference Chart** following this introductory text**.** This is a handy resource for the names, addresses and phone numbers of the key contacts for your Benefits such as the Administrative Office or medical plan networks.
- The **Eligibility Article** outlines who is eligible for coverage and when coverage ends while the **COBRA Article** discusses your options if coverage ends for you or a covered Spouse or Dependent Child.

- Review the **Medical PPO Plan Benefits, Schedule of Medical PPO Plan Benefits and Medical PPO Plan Exclusions Articles.** These describe your Benefits in more detail. There are examples, charts and tables to help clarify key provisions and more technical details of the coverages.
- Review the **Medical Networks Article and the Utilization Review and Case Management Article**. They describe how you can maximize Plan Benefits by following the provisions explained in these Articles.
- Review the Articles on **Dental PPO Plan, Schedule of Dental PPO Benefits and Dental PPO Plan Exclusions** for an explanation of the dental Benefits.
- Review the Article on the **Vision PPO Plan** that includes the Schedule of Vision PPO Benefits and Vision PPO Plan Exclusions for an explanation of the vision Benefits.
- Refer to the **General Provisions Article** for information regarding your rights and information about ERISA, while the **Claim Filing and Appeal Information Article** tells you what you must do to file a claim and how to seek review (appeal) if you are dissatisfied with a claims decision.
- The Article on **Coordination of Benefits** discusses situations where you have coverage under more than one group health care plan, Medicare, another government plan, personal injury protection under mandatory no-fault automobile insurance coverage, workers' compensation, and the Plan's Third Party Recovery Rules.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Administrative Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment, or the existence of other coverage.

Notify the Plan preferably within 31 days, but no later than 60 days*, after any of the above noted events. Failure to give this Plan a timely notice (as noted above) may:

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

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

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

d. may result in your liability to repay the Plan if any Benefits are paid to an ineligible person.

*Note that to enroll in the Plan under the Special Enrollment provisions, the Plan allows enrollment within a 60-day period. See the Eligibility Article for more information.

SPANISH LANGUAGE ASSISTANCE:

Si usted no entiende la información en este documento, haganos el favor de ponerse en contacto por telefono con representantes administrativos del Plan (1-702-851-8286). Para obtener asistencia en Espanol, llame al 1-702-851-8286.

QUESTIONS YOU MAY HAVE

If you have any questions concerning eligibility or the Benefits that you or your family are eligible to receive, please contact the Administrative Office at its phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, the Administrative Office staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your Benefits.

Your most reliable method is to put your questions into writing and fax or mail those questions to the Administrative Office and obtain a written response from the Administrative Office.

In the event of any discrepancy between any information that you receive from the Administrative Office, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to Benefits, if any.

FOR HELP OR INFORMATION

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

ARTICLE II. QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**

Administrative Office
• Eligibility for Coverage
• Plan Benefit Information
• For help understanding the covered wellness/preventive Benefits payable by the Medical Plan
• Claim Forms (Medical and Dental)
• Medical PPO Plan (including behavioral health) Claims Administration and Appeals
• Information about the Hospitalist Program, and Interlink transplant network
• Dental PPO Plan Claims Administration and Level 2 Claim Appeals for the Board of Trustees
• Medicare Part D Notice of Creditable Coverage
• Summary of Benefits and Coverage (SBC)
• COBRA Administration including:
  • Information About COBRA Coverage
  • Cost of COBRA Continuation Coverage
  • COBRA Premium payments
  • Second Qualifying Event and Disability Notification
	Zenith-American Solutions
	2250 South Rancho, Suite 295
	Las Vegas, NV 89102-4454
	Phone: 1-702-851-8286
	Fax: 1-702-734-8619
	Website: www.zenith-american.com or http://www.teamsters14benefits.com
	
	In addition to Zenith's assistance, you can visit these websites below for information on Wellness/Preventive Benefits (including immunizations) payable by the Medical Plan in accordance with Health Reform regulations:
	https://www.healthcare.gov/what-are-my-preventive-care-benefits
	http://www.uspreventiveservicestaskforce.org/BrowseRec/Index
	http://www.hrsa.gov/womensguidelines/
	http://www.cdc.gov/vaccines/schedules/index.html?s_cid=cs_001

Prescription Drug Program for the Medical PPO Plan, administered by the Prescription Benefit Manager (PBM) • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Precertification of Certain Drugs • Information on Drugs with a Quantity Limit • Step Therapy Approval • Specialty Drug Program: Precertification and Ordering	**Elixir** Retail Customer Service Phone: 1-800-361-4542 Website: www.elixirsolutions.com Mail Order Customer Service: 7835 Freedom Ave. NW North Canton, OH 44720 Phone: 866-909-5170 Fax: 866-909-5171 www.elixirsolutions.com Specialty Drug Customer Service: 7835 Freedom Ave. NW North Canton, OH 4472 Phone: 877-437-9012 Precert: 1-800-361-4542 www.elixirsolutions.com

ARTICLE II. QUICK REFERENCE CHART

Information Needed	Whom to Contact
PPO Network for the Medical PPO Plan • Medical Network Provider Directory (*for mental health and substance use network providers, refer to the Behavioral Health row of this Quick Reference Chart)* • Additions/Deletions of Network Providers Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price. If you obtain and rely upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network. Cancer Treatment Centers of America is not covered by this Plan. You must obtain authorization for services from Mayo Clinic or the City of Hope by contacting both the Clinical Director (at the Administrative Office) and the Utilization Management Company.	**Anthem** Visit www.anthem.com and click "Find a Doctor" under "Menu." Under "Search as a Member," enter "JTF" below "Identification number or alpha prefix," then click "Continue" and follow the instructions. Or call the Administrative Office at 1-702-851-8286. You can also find network providers by downloading the Anthem Anywhere mobile app from the App Store (iPhone) or Google Play (Android). **Health Services Coalition (HSC) Hospitals** Phone: 1-702-734-8601 or www.lvhsc.org Includes all hospitals in Las Vegas, Henderson and Boulder City. BlueCard assistance while traveling or living outside the PPO network, call 1-800-810-2583. **CAUTION:** Use of a **non**-PPO network hospital, facility or Health Care Provider **could result in you having to pay a substantial balance on the provider's billing** (see the Definition of "Balance Billing" in the Definition Article of this document). Your lowest out of pocket costs will occur when you use In-Network PPO providers.
Local 14 Family Wellness Centers (Near-site/on-site health care clinics) • Family Wellness Centers provide nearby local, convenient access to medical care and prescription drugs for Medical PPO Plan Participants **without any out-of-pocket cost.** Clinics are staffed with licensed Physicians, Advanced Practitioners, and Medical Assistants to provide quality care. Services provided include: Primary care Urgent care Routine physicals and preventive care Basic diagnostic and laboratory services Chronic condition/disease management Health coaching and risk assessments Access to 50-75 generic prescription drugs dispensed onsite Wellness programs and lifestyle improvement	**Everside Health** 9302 N. Meridian Street, Suite 385 Indianapolis, IN 46260 Phone: (888) 257-7811 Website: www.eversidehealth.com/teamsters14 **Clinic Locations:** **Henderson Clinic** 2739 Sunridge Heights Parkway Henderson, NV 89052 Phone: 702-728-5806 **Northwest Clinic** 2831 Business Park Court, Suite 120 Las Vegas, NV 89128 Phone: 702-844-8143

ARTICLE II. QUICK REFERENCE CHART

Information Needed	Whom to Contact
Behavioral Health Program for the Medical PPO Plan • Behavioral Health and Substance Use Services and Behavioral Health Network Providers • Precertification of certain Behavioral Health Services **CAUTION:** Use of a **non**-PPO network hospital, facility or Health Care Provider **could result in you having to pay a substantial balance on the provider's billing** (see Definition of "balance billing" in the Definition Article of this document). Your lowest out of pocket costs will occur when you use In-Network PPO providers.	**Harmony Healthcare** 9140 West Post Road Las Vegas, NV 89148 Telephone: 1-702-251-8000 or 1-800-363-4874 or 1701 West Charleston, Suite 300 Las Vegas, Nevada 89102 Telephone: 1-702-251-8000 or (East Side – Horizon Ridge) 3041 W. Horizon Ridge Pkwy #140A Henderson, NV 89052 Telephone: 1-702-251-8000 Website for Harmony Healthcare Network Provider Directory: www.harmonyhc.com
Employee Assistance Program (EAP) • This plan offers up to **eight (8) free EAP visits for professional confidential counseling**. The EAP offers professional, confidential information, support and referral to help individuals cope with personal problems that impact their home and work life. EAP counselors can help you with stress, marriage/family/work-related problems, substance use, financial and legal problems.	**Harmony Healthcare** Phone:1-702-251-8000 or 1-800-363-4874 www.harmonyhc.com
Utilization Review and Case Management (UR/CM) for the Medical PPO Plan • Precertification of Admissions and Certain Medical PPO Plan services • Case Management • First Level Appeal of UR/CM decisions	**Innovative Care Management (ICM)** P. O. Box 22386 Portland, OR 97269 Phone: 1-800-862-3338 Website: www.innovativecare.com

ARTICLE II. QUICK REFERENCE CHART

Information Needed	Whom to Contact
Online Provider Visits for Medical PPO Plan Participants • Individuals enrolled in the Fund's medical plan have access to LiveHealth Online, which is a convenient, lower cost alternative to a physician office visit, urgent care visit or non-emergency care in an emergency room. • LiveHealth Online is a Web-based private, secure and convenient live 2-way video visit with a board-certified Physician (an electronic visit called an e-visit using your mobile device or webcam). You can consult with a doctor via on-line video, day or night when your regular doctor is not available. You can use LiveHealth Online when you're traveling, too. • Typical visit is about 10 minutes. You pay **$10 per visit**, not subject to the deductible. You can pay using Paypal, American Express, Visa, MasterCard or Discover card. • Physicians are available 24/7/365 for web or phone-based consultation, including diagnosis and **treatment of medical and/or mental health issues**. • The physician will answer questions, review your medical history, diagnose the condition and can prescribe necessary basic medications. For example, the Physicians can diagnose non-emergency medical problems, like cold and flu symptoms, cough, fever, headache, pink eye, skin rash, allergies, sinus infection, etc. and recommend treatment. • The Physicians average 15 years of practice in medicine, primarily primary care and are specially trained for online visits. • Please note: Due to certain state laws, LiveHealth Online is not available if you are physically located in the states of AR or TX when you place your call. But, if you have a plan from one of these states and are outside of these states when you call, this service is available to you. LiveHealth Online doctors are not able to prescribe controlled substances or lifestyle drugs.	**LiveHealth Online** (from Anthem) Available 24/7/365 To use this electronic visit service you must **sign up online** (it's free to sign up) at www.livehealthonline.com. See also the Frequently Asked Questions on this website for more information. Or, **download the Mobile App for free,** for your smartphone or tablet, from iTunes Apple.com or Google Play at play.google.com/store (search for Mobile Health Consumer) or, go to mobilehealthconsumer.com and choose the User button in the top right corner, then select Register Now. • For the best experience when using LiveHealth Online app on your Android or iOS device, a Wi-Fi connection is recommended. Email and customer support available from **customersupport@livehealthonline.com** or call toll free 1-888-548-3432. **Remember, in an emergency, call 911**.
Vision PPO Plan Claims Administrator • Vision Network Provider Directory • Vision Claims Administration and Appeals	**Vision Service Provider (VSP)** Customer Service: 1-800-877-7195 3333 Quality Drive. Rancho Cordova, CA 95670 Website for Network Provider Directory: www.vsp.com Non-network vision claims only: P. O. Box 997105 Sacramento, CA 95899-7105

ARTICLE II. QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Dental PPO Plan Administrator • Dental Network Provider Directory • Dental Claims Administration and Appeals	**Delta Dental** 1130 Sanctuary Parkway, Suite 600 Alpharetta, GA 30009 **Customer Service: 1-800-521-2651** Website: www.deltadentalins.com Claims Address: P.O. Box 1809 Alpharetta, GA 30023-1809
Dental HMO Plan (insured) • Dental Network Provider Directory • Dental Claims and Appeals • *Dental HMO Benefits are not described in this document. Contact the Administrative Office for information.*	**Liberty Dental** Phone: 1-888-401-1128 Website: www.libertydentalplan.com
COBRA Administrator • Information About COBRA Coverage • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification	See the Zenith American Solutions row at the top of this chart.
Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance Company • *Life and AD&D Benefits are not described in this document. For assistance with these Benefits, contact the Administrative Office for information.*	**ULLICO** 8403 Colesville Rd, Silver Spring, MD 20910 Phone: 202.682.0900 or 1.800.431.5425
Plan Administrator for Local 14	**The Board of Trustees for the Teamsters Security Fund for Southern Nevada-Local 14** 2250 South Rancho, Suite 295 Las Vegas, NV 89102-4454 Phone: 1-702-851-8286
Local 14 HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**Zenith-American Solutions** 2250 South Rancho, Suite 295 Las Vegas, NV 89102-4454 Phone: 1-702-851-8286
Teamsters Local 14 Office	**Teamsters Local 14** 8951 West Sahara Avenue, Suite 100 Las Vegas NV 89117-5899 Phone: 1-702-384-7841 Fax: 1-702-386-4848

ARTICLE III. ELIGIBILITY
HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED AND ENDS

Section A. Eligibility Summary. The following chart summarizes the types of Benefits available for eligible individuals under this Plan:

Type of Benefit	Retirees who are not Medicare-eligible	Dependents of Retirees who are not Medicare-eligible	Retirees who are Medicare eligible	Dependents of Retirees who are Medicare-eligible
Medical Plans (including Outpatient prescription drugs)	Yes, covered until eligible for Medicare	Yes, covered until eligible for Medicare	No	No
Dental Plans	Yes, covered until eligible for Medicare	Yes, covered until eligible for Medicare	No	No
Vision Plan	Yes, covered until eligible for Medicare	Yes, covered until eligible for Medicare	No	No
Life Insurance	Yes, covered until eligible for Medicare	No	No	No
Accidental Death and Dismemberment (AD&D) Insurance	Yes, covered until eligible for Medicare	No	No	No

Section B. Retirees and Medicare. Benefits are provided for **Non-Medicare Retirees** who meet the eligibility requirements established by the Board of Trustees.

1. **Eligibility**. On a self-pay basis, a Non-Medicare Retired Participant ("Retiree") is eligible for the same Benefits, and is subject to the same rules and obligations, as they were under the Active Employee Plan, except where these rules say otherwise. However, **all Plan Benefits coverage under the Fund will end for a Retiree when such Retiree becomes eligible for Medicare.**

   (a) If you choose to decline Non-Medicare Retiree coverage when you initially become eligible, you may delay enrollment for yourself and your eligible Dependents from the date you initially became eligible for Non-Medicare Retiree coverage under the following circumstances:

      1) If you are covered under other health insurance coverage through your Spouse (including COBRA continuation coverage, individual insurance, or Medicare) and that coverage terminates due to divorce, death of Spouse, plan termination or residence change resulting in ineligibility for other health insurance coverage, you may enroll yourself and your Dependent(s) in Retiree coverage as long as enrollment occurs no later than 60 days after the termination date of other insurance coverage.

      2) If you acquire a new Spouse of a new Dependent, as defined by the Plan, you may enroll yourself and your Dependent(s) in Non-Medicare Retiree coverage, as long as enrollment occurs no later than 60 days after the date you acquire the new Dependent(s).

   (b) Note that Eligible Participants who retired prior to January 1, 1994 will maintain eligibility for the Active Employee Plan's Employee and Dependent Life Insurance and Employee Accidental Death and Dismemberment Benefits.

2. **"Retired" Defined**.

   (a) To be Retired under the Plan, for purposes of Non-Medicare Retiree eligibility, a person must be receiving a pension benefit from the Western Conference of Teamsters Pension Plan or from any Pension Plan as negotiated and stated in the Collective Bargaining Agreement. In addition, the Trustees may permit the participation of Retirees in bargaining units who do not receive pension benefits under the applicable Collective Bargaining Agreement, or Retirees from certain Non-bargaining Units whose employer contributed to the Active Plan on such terms and conditions as the Trustees, in their sole discretion determine.

(b) Moreover, to be eligible for Plan Benefits as a Non-Medicare Retiree, the Non-Medicare Retiree must have been eligible under the Active Employee Plan, or through COBRA, for 90 of the 120 months immediately before Retirement.

(c) Up to 30 months of service outside the bargaining unit with the same employer will be counted towards satisfying the 90 month requirement. For new groups or collective bargaining units, active service earned prior to entry into the Plan with the same employer will be counted towards satisfying the 90 month requirement.

(d) For those with at least 60 consecutive months of eligibility as under the Active Employee Plan on or before September 1, 2011, to be eligible for the Non-Medicare Retiree Plan, the Non-Medicare Retiree must have been eligible under the Active Employee Plan, or through COBRA, for 60 consecutive months immediately before retirement.

3. **Important Note**: Non-Medicare Retiree Benefits are not vested or accrued. They are subject to change or discontinuance at any time, in the sole discretion of the Board of Trustees.

4. **Medicare**. If you are approaching age 65, you are not automatically enrolled in Medicare unless you have filed an application and established eligibility for a monthly Social Security benefit. If you have not applied for Social Security Benefits you must file a Medicare application form during the three-month period prior to the month in which you become 65 years of age in order for coverage to begin at the start of the month in which you reach age 65. Call or write your nearest Social Security Office 90 days prior to your 65th birthday and ask for an application card.

5. **Retirees eligible for Medicare will not be eligible for Benefits provided by the Fund**. See also Section K in this Article on termination of coverage. The Fund has partnered with a company to provide benefit options that best suit each Medicare Retiree's needs and budget through a private Medicare Exchange.

   (a) Medicare-eligible Retirees will not be required to pay monthly self-payment contributions to the Fund. Instead, they will be fully financially responsible for the plans in which they choose to enroll.

Medicare-eligible Retirees, or Retirees covered under Indian Health Services, that have an eligible Dependent covered under the Fund that is not eligible for Medicare, or that is under age 65 with end-stage renal disease ("ESRD") and eligible for Medicare, can continue coverage for that Dependent under the Fund by paying the appropriate monthly self-payment contribution rate established by the Board of Trustees.

Section C. Dependents

1. If a Non-Medicare Retiree is eligible for coverage and has Dependents, the Retiree's Dependents' are eligible for coverage only if those Dependents are not also eligible for Medicare.

2. Eligible Dependents can be covered for health care Benefits (medical including prescription drugs, dental, vision, and life insurance). The coverage for Dependents will be effective:

   (a) on the date the Non-Medicare Retiree becomes eligible for coverage if the Dependent is enrolled during Initial Eligibility Enrollment; or

   (b) the date the Dependent meets the Definition of a Dependent and is enrolled through the New Dependent Enrollment;

4. **The following Dependents are eligible for Benefits**:

   (a) The Non-Medicare Retiree's **legal Spouse**. The following are not defined as a Spouse under this Plan: a legally separated Spouse, a civil union, a divorced former Spouse of a Non-Medicare Retiree, a common law marriage, or a Spouse of a Dependent Child.

   (b) The **Non-Medicare Retiree's Children from birth until the end of the month in which they have their 26th birthday**, regardless of whether a Child has coverage through the Child's own employer or the employer of the Child's Spouse.

   (c) The Definition of "Children" includes your **natural Children, stepchildren, legally adopted Children, Children placed for adoption, and Children for whom the Retiree is a court-appointed guardian,** who are listed on the Retiree's enrollment card in the Administrative Office. An adopted Dependent Child will be covered from the date that Child is adopted or "Placed for Adoption" with the Retiree, whichever is earlier, provided the enrollment procedure of this Plan is followed. A Child is "Placed for Adoption" on the date the Retiree first become legally obligated to provide full or partial support of the Child whom they plan to adopt.

   (d) **Disabled Adult Child:** A Disabled Adult Child may be eligible for Benefits. The Plan will require initial and periodic proof of disability. You will have 31 days from the date of the request to provide this proof to the Administrative Office before the Child is determined to be ineligible. The Plan may require, at reasonable times during the two years following the Child's attainment of the limiting age, subsequent proof of the Child's incapacity

and dependency. After the two year period, the Plan may require additional proof of the incapacity and dependency once a year. To be eligible as a Disabled Adult Child, the individual must meet all of the following eligibility requirements:

1) is an **unmarried** Dependent Child (as defined above) of a covered Retiree or Spouse; and
2) is **age 26 or older**; and
3) is **permanently and totally disabled** (for example the disability has lasted 12 months, is expected to last 12 months, or is expected to result in death); and
4) has a **disability that causes the individual to be incapable of self-sustaining employment** (substantial gainful employment) **as a result of that Disability**, and chiefly relies on the Retiree or Spouse for support and maintenance; and
5) the **Disability existed prior to attainment of the age that causes a non-disabled Dependent Child's coverage to end under this Plan** (e.g. the Child's 26th birthday); and
6) **was covered under this Plan on the day before their 26th birthday.**

(e) Full-time, active members of the armed forces are not eligible for coverage. Continuation of coverage during military leave is discussed later in this Article.

(f) A Dependent Child will not lose eligibility if he or she becomes employed and obtains medical coverage through his or her employer. Dependent Children who obtain separate medical coverage through their employers may continue to receive coverage through the Plan; however, coverage under this Plan will always be secondary to the Child's coverage through their employer(s).

(g) The following **Dependents are not eligible for coverage** under this Plan: foster Children, a Spouse of a Dependent Child (e.g. Retiree's son-in-law or daughter-in-law), and a Child of a Dependent Child (e.g. Retiree's grandchild).

5. **Dependent Enrollment**:

(a) **Retirees must enroll their eligible Dependent (Spouse and Children) in order for those Dependent to be eligible for Benefits under the Plan**. There are three opportunities to enroll Dependents for coverage under this Plan: Initial Enrollment (becoming enrolled at the same time the Retiree is first eligible), New Dependent Enrollment (which includes Special Enrollment), and Open Enrollment.

Retirees must enroll their eligible Dependents when they start eligibility as a Retiree.

(b) **Initial Eligibility Enrollment**: This is the first opportunity for the Retiree to enroll his/her eligible Dependents. A newly eligible Retiree has **60 days** in which to enroll his/her Dependents. If the Dependent is enrolled within **60 days** of the Retiree's initial eligibility, the eligible Dependent's coverage will become effective on the date the Retiree's initial eligibility becomes effective. Failure to enroll during Initial Enrollment means the Dependent will not receive coverage until the first day of new plan year after the Retiree does enroll the Dependent during the Open Enrollment period (see the Open Enrollment provision below).

(c) **New Dependent Enrollment**: This is the first opportunity for the Retiree to enroll a Dependent **because of an event such as marriage, birth, adoption, or placement for adoption**. If a Retiree enrolls a new Dependent Child (newborn/adopted/placed for adoption/new stepchild) or a new Spouse **within 60 days** of the event (the Child's birth, adoption, placement for adoption, or the Retiree's marriage), coverage is effective as of the date of the event. Failure to enroll during New Dependent Enrollment means the Dependent will not receive coverage until the first day of the new plan year after the Retiree does enroll the Dependent during the Open Enrollment period. (A Child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the Child whom you plan to adopt.)

(d) **How to Enroll a Dependent for Benefits:** To request enrollment, a Retiree must contact the Administrative Office (by telephone, fax, postal service mail or hand delivery) and indicate his/her desire to enroll his/her Dependent in the Plan. (The address, phone number, and fax for the Administrative Office is listed on the Quick Reference Chart in the beginning of this document.)

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

- submit a completed written enrollment form(s) (that may be obtained from and submitted to the Administrative Office), and
- provide proof of Dependent status (as requested), and
- perform these steps above in a timely manner according to the timeframes noted under the Initial, New Dependent, or provisions of this Plan.

Proper enrollment is required for coverage under this Plan. Note that if enrollment has been requested within the required time limit but proper enrollment including paperwork and Social Security Number has not been completed and submitted, claims may not be able to be considered for payment until such information has been completed and submitted to the Administrative Office.

(e) **Dependent Social Security Numbers Required.**

DEPENDENT SOCIAL SECURITY NUMBERS

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

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

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

(f) **A person who has not properly enrolled by requesting enrollment in a timely manner, has no right to any coverage for Plan Benefits or services under this Plan**.

(g) **Disenrollment of a Dependent:** You must immediately notify the Board of Trustees, in writing, of any change in eligibility status for any Dependent enrolled for coverage under the Plan, such as divorce or other event resulting in a loss of eligibility. **A failure to notify the Plan of such a change will be deemed an act of omission constituting fraud or an intentional misrepresentation of material fact by the Participant and ineligible Dependent**.

In addition, you are permitted to remove an eligible Dependent from coverage under the Plan for a reason other than loss of eligibility. However, the elective Dependent disenrollment is only permitted if the Retiree demonstrates **"just cause"** for the disenrollment. A just-cause disenrollment request must be submitted in writing to the Administrative Office. Please contact the Administrative Office for an elective disenrollment form which requests the desired disenrollment date.

A just cause disenrollment request will be reviewed by the Board of Trustees within 90 days of the date of the request. The Board of Trustees has sole discretion to determine the documentation and circumstances that may be required to demonstrate just cause of the elective disenrollment, and the effective date of the elective disenrollment. The decision by the Board of Trustees is final.

A request for elective disenrollment is not a COBRA qualifying event for the individual being disenrolled. Once disenrolled from the Plan, the Dependent can only be re-enrolled in accordance with the Plan's Initial Eligibility Enrollment or New Dependent/Special Enrollment process described in this Article or, after 12 months have elapsed from the date of the disenrollment, the Participant can request that their Dependent be reenrolled in accordance with the Open Enrollment process described in this Article.

6. **Qualified Medical Child Support Orders**. Under the Omnibus Budget Reconciliation Act of 1993, the Plan must recognize any Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice and enroll the Child of a Plan Participant as directed by the Order, provided the Child is otherwise eligible.

(a) A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court that:

1) provides the Child of a Plan Participant with Child support or health Benefits under the Plan; or

2) enforces a state law relating to medical Child support that provides in part that if the Retiree parent does not enroll the Child, the non-Retiree parent or State agency may enroll the Child.

(b) To be Qualified, a Medical Child Support Order must clearly specify:

1) the name and last known mailing address of the Participant and the name and mailing address of each Child covered by the order;

2) a reasonable description of the type of coverage to be provided by the Plan to each such Child or the manner in which such type of coverage is to be determined;

3) the period to which such Order applies; and

4) the name of each plan to which such Order applies.

(c) Further, a Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under the Plan.

(d) Payment of Benefits by the Plan under a Medical Child Support Order to reimburse expenses advanced by a Child or his custodial parent or legal guardian shall be made to the Child or his custodial parent or legal guardian. Further the Child may designate an agent to receive notices, including a notice of qualification.

(e) No eligible Retiree's Child covered by a Qualified Medical Child Support Order ("QMCSO") will be denied coverage on the grounds that the Child is not claimed as a Dependent of the eligible Retiree's Federal income tax return or does not reside with the eligible Retiree.

(f) Contact the Administrative Office for the procedures you should follow for approval of Qualified Medical Child Support Orders.

(g) The Plan's costs in reviewing and approving QMCSOs, including legal fees, consultant's fees and auditor's fees, if any, shall be allocated to the Plan Participant and reimbursed to the Plan by the Plan Participant. Such amounts shall be applied as an "overpayment" by the administrator and recouped from future Benefits of the Participant. The Administrator shall send a notice explaining the charge to the Participant paying it. There is no cost for a copy of the Plan's procedures for a QMCSO.

Section E. Surviving Dependents of a Deceased Non-Medicare Retiree.

1. In the event of the death of a Covered Non-Medicare Retiree, the surviving Spouse, and eligible Dependent Children may continue coverage, except for Dependent Life Insurance, under the Plan by making the necessary self-payments to the Plan on a timely basis.
2. Coverage for the surviving Spouse, or eligible Dependents will terminate on the date of remarriage or death of the surviving Spouse, on the date the surviving Spouse becomes eligible for Medicare, or loss of Dependent eligibility under the Dependent's eligibility rules.

Section F. Enrollment Card.

1. To receive Benefits under the Plan, you must complete an enrollment card. You can obtain an enrollment card at the Plan Administrative Office or your Union Office. Once you fill out the card, return it to the Plan Administrative Office.

2. **You and your Dependents will not receive Benefits unless your signed enrollment card is on file at the Plan Administrative Office**. When you sign the enrollment card you are certifying:

   (a) That the information on the enrollment card is true, correct and current as of the date signed. You are also agreeing to immediately notify the Board of Trustees, in writing, of any changes in this information, including any change in eligibility status for any Dependent listed on the enrollment card. A failure to notify the Plan of such a change will be deemed an act or omission constituting fraud or an intentional misrepresentation of material fact by the Participant and ineligible Dependent. The Participant and the ineligible Dependent are jointly and severally liable to the Plan for amounts paid on behalf of such ineligible Dependent, including legal and other costs of the Plan incurred in obtaining recovery of the amounts paid by the Plan. Receipt of Benefits is consent and agreement by the ineligible person to such liability.

   (b) That you acknowledge the right of the Board of Trustees to require, and promptly receive from the Retiree, **proof of eligibility status**, such as marriage licenses, birth certificates, domestic relations decrees or any other proof of eligibility, or other information as the Board of Trustees, in its sole discretion, may request.

3. **Proof of Dependent Status**.

   (a) **Note that failure to provide timely proof of Dependent status (at each enrollment opportunity) means that claims submitted to the Plan for the Dependents will not be able to be considered for payment until such proof is provided**.

   (b) Proof of Dependent Status includes:

      1) **Marriage:** the certified marriage certificate and spousal affidavit of other coverage.

      2) **Birth:** the certified birth certificate showing biological Child of the Retiree.

      3) **Stepchild:** the certified birth certificate, divorce decree, and marriage certificate.

      4) **Adoption or placement for adoption**: court order paper signed by the judge showing that the Retiree has adopted or intends to adopt the Child, birth certificate.

      5) **Legal Guardianship:** the court-appointed legal guardianship documents and certified birth certificate.

      6) **Disabled Dependent Child:** Current written statement from the Child's Physician indicating the Child's diagnoses that are the basis for the Physician's assessment that the Child is currently mentally or physically disabled (as that term disabled is defined in this document) and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability; and Dependent chiefly on you and/or your Spouse for support and maintenance. The plan may require that you show proof of initial and ongoing disability and that the Child meets the Plan's Definition of Dependent Child including proof that the Child is claimed as a Dependent for federal income tax purposes.

      7) **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document signed by a judge or a National Medical Support Notice.

   (c) A Dependent may not be enrolled for coverage unless the Retiree is also enrolled.

   (d) A Dependent of a Non-Medicare Retiree may continue enrollment after the Retiree becomes eligible for Medicare, or the Retiree is covered under Indian Health Services, but only so long as the Dependent is not also eligible for Medicare.

   (e) You must agree to promptly furnish such proof or information to the Board of Trustees and further agree that furnishing such proof or information satisfactory to the Board of Trustees is a precondition to the payment of any Benefits for the Retiree or on your behalf of your Dependents.

   (f) You should understand that health Benefits are not vested rights and that the Board of Trustee has full authority to modify, limit or terminate health care Benefits at any time the Board of Trustees deems appropriate.

   (g) If the Plan pays Benefits to you or on behalf of any person listed as a Dependent on your enrollment card, when you or any such person is not in fact eligible or entitled to Benefits or if the Plan otherwise mistakenly pays Benefits, the Retiree agrees to promptly reimburse the Plan in full for any money so paid. You also agree that the Trustees, in their sole discretion, may deduct or offset any such money from future Benefits for you or any Dependent. If the

Plan files any legal action against you to recover any such money, you agree to pay all attorney fees and costs of the Plan, whether or not such an action proceeds to judgment.

4. **Special Rules For Enrollment.**

   (a) No individual may be covered under this Plan both as a Retiree and as a Dependent.

   (b) No individual may be covered under both the Non-Medicare Retiree Plan and the Active Employee Plan.

   (c) However, when both parents are Teamsters Local 14 members, a Dependent Child may then be covered as the Dependent Child of more than one Employee or Retiree.

Section G. Termination of Coverage.

See also the COBRA provisions of this Plan for information on temporarily self-paying for Benefits after coverage ends under this Plan.

1. **Retiree coverage ends on the earliest of:**

   (a) The last day of the month prior to the month in which the Retiree becomes eligible for Medicare;

   (b) End of the period for which the last required contribution was made;

   (c) The date of the Retiree's death;

   (d) Termination date of the Plan;

   (e) The date Retiree coverage is discontinued under the Plan;

   (f) Date of the Retiree's death.

   (g) The date the Retiree no longer meet the definition of a Retiree.

2. **Coverage for the eligible Dependent(s) of a Retiree will terminate upon the earliest of:**

   (a) The first day of the month in which the eligible Dependent becomes eligible for Medicare;

   (b) The date the eligible Dependent no longer qualifies as a Dependent under the Fund's eligibility rules;

   (c) Termination date of the Plan; or for a particular Dependent's benefit, the termination date of that benefit;

   (d) Termination date of the Dependents' coverage under the Plan;

   (e) Date a Dependent Spouse enters the full-time military armed forces of any country;

   (f) The first day of the month for which the eligible Dependent fails to pay the required self-payment contribution rate.

3. **Coverage of a surviving Spouse, or surviving Dependent Child of a deceased Retiree will terminate upon the earliest of:**

   (a) The first day of the month in which the Spouse, or Dependent Child becomes eligible for Medicare;

   (b) The date of remarriage of the Spouse;

   (c) The date the eligible Dependent Child no longer qualifies as a Dependent under the Fund's eligibility rules;

   (d) The date of death of the Spouse, or Dependent Child;

   (e) Termination date of the Plan; or for a particular Dependent's benefit, the termination date of that benefit;

   (f) Termination date of the Dependents' coverage under the Plan;

   (g) Date a Spouse, or Dependent Child enters the full-time military armed forces of any country;

   (h) The first day of the month for which the Spouse, or Dependent Child fails to pay the required self-payment contribution rate.

4. **Additional Causes of Termination.** Additionally, your coverage will end under the Plan:

   (a) If you or your covered Dependent fails to make required COBRA payments;

   (b) If you or your covered Dependent fails to notify the Plan Administrative Office of an event that causes you or your Dependent to lose eligibility for Plan Benefits within 60 days of the incident:

   (c) If you or your covered Dependent fails to provide the Plan Administrative Office with a copy of the Social Security Disability Award; or

   (d) If you or your covered Dependent fails to comply with the Plan's rules.

(e) **False information and fraud**. If a Retiree or Dependent knowingly submits false information or knowingly fails to submit or conceals material information in order to achieve eligibility or obtain any benefit from the Fund, or otherwise commits fraud on the Fund, as determined solely by the Trustees, the Fund may deny Benefits or revoke coverage or eligibility for such time (including permanently) and on such terms as they deem just and appropriate. The Retiree and Dependent will be jointly and severally liable for any Benefits paid by the Plan for the ineligible Dependent. Receipt of Benefits is consent and agreement by the ineligible person to such liability.

(f) **The Plan may retroactively cancel coverage** (a rescission), such as when contributions and self-payments are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled under the Plan (for example, an ex-spouse, over age or ineligible dependent child, etc.) is considered fraud. The Plan will provide at least 30 days advance written notice to each participant who will be affected before coverage is rescinded.

Continuation Of Coverage After Coverage Terminates: See the COBRA Article for information on continuing your health care coverage.

7. When coverage under this Plan terminates you may have the option to:

a. buy temporary continuation of this group health plan coverage by electing COBRA; or

b. for insured health plan options, convert your group insurance coverage to an individual insurance policy (when permitted by the insurance company); or

c. look into your options to buy an individual insurance policy for health care coverage from the **Health Insurance Marketplace**.

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan.

Section K. Notice to the Plan.

1. You, your Spouse, or any of your Dependent Children **must notify the Plan preferably within 31 days but no later than 60 days*** after the date a:
   (a) Spouse ceases to meet the Plan's Definition of Spouse (such as in a divorce);
   (b) Dependent Child ceases to meet the Plan's Definition of Dependent (such as the Dependent Child reaches the Plan's limiting age, or the Dependent Child age 26 and older ceases to have any physical or mental disability);
2. ***Failure to give this Plan a timely notice (no later than 60 days as noted above) may cause** your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or may result in a Participant's liability to the Plan if any Benefits are paid to an ineligible person.

ARTICLE IV. MEDICAL PPO PLAN BENEFITS

Section A. Eligible Medical Expenses.

1. You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called "eligible medical expense." Eligible medical expenses are determined by the Board of Trustees or its designee, and are limited to those that are:

   (a) **"Medically Necessary,"** but only to the extent that the charges are **"Allowable Expenses"** (as those terms are defined in the Definitions Article of this document); and

   (b) **not services or supplies that are excluded** from coverage (as provided in the Medical PPO Plan Exclusions Article of this document); and

   (c) **not services or supplies in excess** of a Maximum Plan Benefit as shown in the Schedule of Medical PPO Plan Benefits; and

   (d) **for the diagnosis or treatment of an injury or illness** (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical PPO Plan Benefits in this document); and

   (e) **expenses incurred while you are covered under this Plan**. An expense is incurred on the date you receive the service or supply for which the charge is made.

2. Generally, **the Plan will not reimburse you for all Eligible Medical Expenses**. Usually, you will have to satisfy some Deductibles and pay some Coinsurance, or make some Copayments toward the amounts you incur that are Eligible Medical Expenses. See also the information in this Article on the Out-of-Pocket Limit on in-network cost-sharing.

Section B. Non-Eligible Medical Expenses.

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

Section C. PPO In-Network Health Care Provider Services.

1. **In-Network (also called Preferred Provider, Participating Provider, or Contracted Provider):** If you receive medical services or supplies from a Health Care Provider that is contracted with the Plan's PPO networks, you will be responsible for paying less money out of your pocket for Eligible Medical Expenses. Health Care Providers who are under a contract with a PPO have agreed to accept the discounted amount the Plan pays for covered services, plus any additional Copayments, Deductibles or Coinsurance you are responsible for paying, as payment in full, except with respect to claims involving a third party payer, including auto insurance, workers' compensation or other individual insurance. In those cases, the contracts of Health Care Providers with the PPO do not require them to adhere to the discounted amount the Plan pays for covered services, and they may charge in excess of what this Plan considers an Allowable Expense.

2. **Out-of-Network (also called Non-Network, Non-PPO, Non-Participating or Non-Contracted):** refers to providers who are not contracted with the Plans' PPO Networks and who **do not** generally offer any fee discount to a Plan Participant or to the Plan. These Out-of-Network Health Care Providers **may bill a Plan Participant a non-discounted amount** for any balance that may be due **in addition to** the Allowable Expense payable by the Plan, also called balance billing. See also the Medical Networks Article of this document. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. To avoid balance billing, use in-network providers.

   REMINDER:

   Cancer Treatment Centers of America is not covered by this Plan. You must obtain authorization for services from Mayo Clinic or the City of Hope by contacting both the Clinical Director (at the Administrative Office) and the Utilization Management Company.

3. **Example Of The Plan's Payment And Your Cost-Sharing When Using PPO And Non-PPO Providers.** Let's say you have already met your annual Deductible and you receive a surgical procedure at your doctor's office and the doctor's charge is $350. For this surgical procedure, the Allowable Expense for a Non-PPO provider is $300. The Plan has negotiated with their PPO provider that the PPO providers will charge only $200 for that same procedure.

Here's an example of the amounts you and the Plan will pay if using PPO or NON-PPO providers:

	PPO PROVIDER	NON-PPO PROVIDER
Provider's Billed Charges:	$350	$350
Plan's Allowable Expense:	$200 (the pre-negotiated discounted rate)	$300 (the amount the Plan allows toward the Non-PPO provider's services)
The Plan pays:	$150 (100% of $200 minus your $50 Copayment)	$150 (50% of the Allowable Expense amount)
You pay:	**$50** (your PPO Copayment)	**$200** (you pay 50% of the Allowable Expense plus the $50 which was above the amount the Plan considered to be an Allowable Expense)
	You pay the least money when using PPO Providers	**You pay the most money when using Non-PPO Providers**

Section D. Deductibles.

1. The Deductible is the amount you must pay each Calendar Year before the Medical PPO Plan pays Benefits. The amount applied to the Deductible is the lesser of billed charges or the amount considered to be an Allowable Expense under this Plan.
2. Each Calendar Year, you (and **not** the Plan) are responsible for paying all of your Eligible Medical Expenses until you satisfy the annual Deductible and then the Plan begins to pay Benefits.
3. Deductibles are applied to the Eligible Medical Expenses in the order in which claims are processed by the Plan.
4. Deductibles under this Plan are accumulated on a Calendar Year basis.
5. Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. As a result, Non-Eligible Medical Expenses described above do not count toward the Deductibles.
6. Copayments and penalties for failure to obtain preauthorization for services do not accumulate to meet a Deductible.
7. There are **two types of annual Deductibles**: Individual and Family.
   (a) The **Individual Deductible** is the maximum amount one covered person has to pay toward Eligible Medical Expenses before Plan Benefits begin.
   (b) The **Family Deductible** is the maximum amount that a **family of three or more persons** is responsible for paying toward Eligible Medical Expenses before Plan Benefits begin.
   (c) The amount of the Deductible is listed on the Schedule of Medical PPO Plan Benefits.
8. **Deductible Carryover**: The Deductible carryover is the amount of covered expenses incurred in the last three months of the Calendar Year that carryover or accumulate to meet the next year's annual Deductible amount. The carryover amount applies toward the individual Deductible for the following Calendar Year.
9. **Note that Deductibles are NOT interchangeable, meaning you may not use any portion of an In-Network Deductible to meet an Out-of-Network Deductible and vice versa**.
10. **Expenses Not Subject to Deductibles**: Certain Eligible Medical Expenses are not subject to Deductibles, such as certain preventive/wellness screening services. See the Schedule of Medical PPO Plan Benefits to determine when Eligible Medical Expenses are not subject to Deductibles.
11. The Medical Plan Deductible does not need to be met before the Plan pays toward outpatient prescription drug Benefits.
12. Retail and Mail Order prescription drug Copayments do not accumulate to meet the annual Deductible.

Section E. Coinsurance.

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

2. If you use the services of a Health Care Provider who is a member of one of the Plan's PPOs, you will be responsible for paying less money out of your pocket. This feature is described in more detail in the Medical Network Article of this document and the difference in Coinsurance between in-network provider and non-network providers is displayed in the Schedule of Medical PPO Plan Benefits.

3. **Coinsurance When You Don't Comply with Utilization Review and Case Management Programs**: If you fail to follow certain requirements of the Plan's Utilization Review and Case Management Program (as described in the Utilization Review and Case Management Article of this document) the Plan may pay a smaller percentage of the cost of those services, and you will have to pay a greater percentage of those costs, and the additional amount you'll have to pay will not be subject to the Plan's Deductibles described below. This feature is described in more detail in the Utilization Review and Case Management Article of this document.

4. See the Coinsurance/Copay Limit discussed under the "Out-of-Pocket Limit" in Section G below.

Section F. Copayment.

1. A Copayment (or Copay, as it is sometimes called) is a set dollar amount you (and **not** the Plan) are responsible for paying when you incur certain Eligible Medical Expenses. The Plan's Copayments are indicated in the Schedule of Medical PPO Plan Benefits. Copayments do not accumulate to meet a Deductible.

Section G. Out-Of-Pocket Limit (Annual Limit On In-Network Cost Sharing).

1. This Plan has an Out-of-Pocket Limit (also referred to as an Out-of-Pocket Maximum) which limits your annual cost-sharing for covered essential health Benefits received from in-network providers related to Medical PPO Plan Deductibles, Coinsurance, and Copayments. The amount of the annual Out-of-Pocket Limit is listed on the Schedule of Medical PPO Plan Benefits.

2. The Out-of-Pocket Limit is accumulated on a Calendar Year basis.

3. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.

4. The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services.

5. The family Out-of-Pocket Limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual Out-of-Pocket Limit.

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

   (a) Premiums and contributions for coverage (when applicable),

   (b) Expenses for medical services or supplies that are not covered by the Medical PPO Plan,

   (c) Charges in excess of the Allowable Expense determined by the Plan which includes balance billed amounts for non-network providers,

   (d) Penalties for non-compliance with Utilization Review and Case Management programs,

   (e) Expenses for the use of non-network providers,

   (f) Dental Plan or Vision Plan Benefits, and

   (g) Expenses that are not considered to be essential health Benefits.

7. **Coinsurance/Copay Limit**: The Coinsurance/Copayment limit is the most you pay in coinsurance or copayments related to an inpatient health care facility admission before the Plan starts to pay 100% toward eligible coinsurance and copayment. The Plan will continue the coinsurance/copay limit of $1,500 per admission related to any inpatient health care facility admission.

Section H. Maximum Plan Benefits.

1. **Types of Maximum Plan Benefits**: There are two general types of maximum amounts of Benefits payable by the Plan on account of medical expenses incurred by any covered Plan Participant under this Plan. They are described below as a Limited Overall Maximum Plan Benefit and Annual Maximum Plan Benefit.

   (a) **Limited Overall Maximum Plan Benefits:** Certain Plan Benefits are subject to limitations that are not considered Annual maximums and are called Limited Overall Maximums. An example would be a limit per injury or illness or per device/occurrence. The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the amounts of these maximums are identified in the Schedule of Medical PPO Plan Benefits. Once the Plan has paid the Limited Overall Maximum Plan Benefit for any of those services or supplies on behalf of any Covered Individual, no further Plan Benefits will be paid for those services or supplies on account of that Covered Individual.

(b) **Annual Maximum Plan Benefits:** Plan Benefits are subject to an overall Annual Plan Maximum of $1,000,000. Once the Plan has paid the overall Annual Plan Maximum, no further Plan Benefits will be paid for the balance of the Calendar Year. In addition, Plan Benefits for certain Eligible Medical Expenses are subject to separate Annual Maximums for specific services per covered individual or family during each Calendar Year. Once the Plan has paid the Annual Maximum for any of those services or supplies on behalf of any Covered Individual or family, no further Plan Benefits will be paid for those services or supplies on account of that individual or family for the balance of the Calendar Year. The services or supplies that are subject to a separate Annual Maximum are identified in the Schedule of Medical PPO Plan Benefits.

Section I. Coverage Of Certain Over-The-Counter (OTC) and Prescription Drugs.

1. **For an over-the-counter or prescription drug to be covered by the Plan, the drug must be:**
   (a) obtained through the outpatient Prescription Drug Program at a participating network retail or mail order pharmacy and
   (b) presented to the pharmacist with a prescription for the drug from your Physician or Health Care Practitioner.
   (Certain types of insulin are payable by the Plan without a prescription).
2. The following chart outlines certain OTC and prescription drugs that are payable by the non-grandfathered Medical PPO plan, **at no charge, when purchased at an in-network retail pharmacy location**, in accordance with Health Reform regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations. Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of OTC or prescription drugs, this Plan will comply with the new requirements on the date required.

Drug Name	Who Is Covered for this Drug?	Your Cost-Sharing?	Payment Parameters in addition to a prescription from your Physician or Health Care Practitioner:
Aspirin	• For pregnant women who are at high risk for preeclampsia (a pregnancy complication). • Low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	None, if payment parameters are met	• For pregnant women at high risk for preeclampsia: plan covers daily low dose aspirin (81mg) as preventive medication after 12 weeks gestation. • The use of aspirin is recommended when the potential benefit outweighs the potential harm due to an increase in gastrointestinal hemorrhage. • Since dosage is not established by USPSTF, plan covers generic aspirin products limited to one tablet per day.
FDA-approved contraceptives for females, such as birth control pills, spermicidal products and sponges.	All females	None, if payment parameters are met	Up to a month's supply of FDA-approved contraceptives per purchase (or 3 month supply of certain 90-day dosed contraceptives like Seasonale) are payable under the plan's Prescription Drug Program for females younger than 60 years of age. Generic FDA approved contraceptives are at no cost to the Participant. Brand contraceptives are payable only if a generic alternative is medically inappropriate.
Folic acid supplements	All females planning or capable of pregnancy should take a daily folic acid supplement containing 0.4 - 0.8mg of folic acid.	None, if payment parameters are met	Excludes women >55 years of age, and products containing > 0.8mg or < 0.4mg of folic acid. Plan covers generic folic acid up to one tablet per day.

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

Section J. Schedule Of Medical PPO Plan Benefits.

1. A schedule of the Medical PPO Plan Benefits, appears on the following pages in a chart format. Each of the Plan's Benefits is described in the first column. Explanations and limitations that apply to each of the Benefits are shown in the second column. Specific differences in the Benefits when they are provided In-Network (when you use PPO Network Providers) and Out-of-Network (when you use Non-PPO, Non-Network Providers) are shown in the subsequent columns.
2. Deductibles, Out-of-Pocket Limit, Hospital Services (Inpatient) and Physician and Health Care Practitioner Services are listed first because these categories of Benefits apply to most (but not all) health care services covered by the Plan. They are followed by descriptions, appearing in **alphabetical** order, of all other Benefits for specific health care services and supplies that are frequently subject to limitations and Exclusions.
3. Unless there is a specific statement in the Schedule of Medical PPO Plan Benefits, all Benefits shown are subject to the Plan's Deductibles.

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

TIME LIMIT FOR INITIAL FILING OF HEALTH CARE CLAIMS

All claims must be submitted to the Plan as soon as possible after the date of service but not later than 12 months from the date of service for health claims. No Plan Benefits will be paid for any claim submitted after this period. Note, however, the Medical PPO network providers are required by their network contract to submit claims within 90 days of the date of service.

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

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Annual Maximum	• Plan Benefits are subject to an overall Annual Plan Maximum of $1,000,000. • Once the Plan has paid the overall Annual Plan Maximum, no further Plan Benefits will be paid for the balance of the Calendar Year. • In addition, Plan Benefits for certain Eligible Medical Expenses are subject to separate Annual Maximums for specific services per covered individual or family during each Calendar Year.		
Overall Annual Deductible for the Medical Plan • The Deductible is the amount you must pay each Calendar Year before the Plan pays Benefits. • The amount applied to the Deductible is the lesser of billed charges or the amount considered to be an Allowable Expense under this Plan.	• **Note that these Deductibles are NOT interchangeable.** This means you **may not** use any portion of an In-Network Deductible to meet an Out-of-Network Deductible and vice versa. • Certain other Benefits outlined in this Schedule may also have a **benefit-specific Deductible** in addition to this overall annual medical plan Deductible.	$500 per person $1,500 per family	$1,500 per person $4,500 per family
Out-of-Pocket Limit This Plan has an Out-of-Pocket Limit which caps your annual cost-sharing for covered essential health Benefits received from in-network providers related to Medical PPO Plan Deductibles, Coinsurance, and Copayments. • The Out-of-Pocket Limit is accumulated on a Calendar Year basis. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services. • The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual out-of-pocket limit.	• **The Out-of-Pocket Limit does not include or accumulate**: a) Premiums and contributions for coverage (when applicable), b) Expenses for medical services or supplies that are not covered by the Medical PPO Plan, c) Charges in excess of the Allowable Expense determined by the Plan which includes balance billed amounts for non-network providers, d) Penalties for non-compliance with Utilization Review and Case Management programs, e) Expenses for the use of non-network providers f) Dental Plan or Vision Plan Benefits, g) Expenses that are not considered to be essential health Benefits, • In addition to the Plan's Out-of-Pocket Limit, the Plan also has a Coinsurance/Copay Limit explained below: • **Coinsurance/Copay Limit**: The Coinsurance/Copayment Limit is the most you pay in coinsurance or copayments related to any inpatient health care facility admission before the Plan starts to pay 100% toward eligible coinsurance and copayment. The Plan will continue the coinsurance/copay limit of $1,500 per admission related to any inpatient health care facility admission.	The **annual Out-of-Pocket Limit for Medical Plan benefits** (excluding outpatient drugs) is: $6,000 per person $12,000 per family The **annual Out-of-Pocket Limit for outpatient drugs** is: $1,500 per person $3,000 per family The Plan will continue the coinsurance/copay limit of $1,500 per admission related to an inpatient health care facility admission.	No limit

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*

Hospital Services (Inpatient)
• Room & board facility fees in a semiprivate room with general nursing services.
• Specialty care units (e.g., intensive care unit, cardiac care unit).
• Lab/x-ray/diagnostic services.
• Related Medically Necessary ancillary services (e.g., prescriptions, supplies).
• Newborn care and newborn circumcision (hospital Deductible and medical plan waived for routine nursery care)
• For eligible females, Birth (Birthing) Center charges are paid in the same manner as a hospital is paid. See also the Maternity row for more information.
	A Hospital Admission Copay is applied for each inpatient admission in addition to the annual medical plan Deductible.
	• **Elective Hospitalization requires precertification. All Hospitalization is subject to concurrent review.** See the Utilization Review and Case Management Article for details.
	• Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms.
	• Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if the Utilization Review and Case Management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services.
	  • No payment is extended toward the associated dental professional fee services provided while at a hospital or outpatient surgery facility.
	  • **Planned use of a hospital or outpatient surgery facility for a Dental purpose requires precertification.** See the Utilization Review and Case Management Article for details.
	• See the Eligibility Article for how to properly enroll Newborns so coverage can be considered.
	• Specialty care hospitals, also called long term care acute (LTAC) hospitals, are discussed under the Skilled Nursing Facility row in this Schedule.
		After the Annual Deductible Is met there is a **$300 copay for the first day, then $150 copay per day following** per admission, up to the Coinsurance/Copay limit of $1,500 per admission; then the Plan pays 100% of coinsurance.	After the Annual Deductible is met there is an additional **$1,000 Inpatient Copay** per admission, then the member is responsible for 50% Coinsurance, (Plan pays 50% of allowable expenses), up to the Coinsurance/Copay limit of $1,500 per admission; then the Plan pays 100% of coinsurance.
			
			Reminder, Out-of-Network providers are paid according to the Allowable Expense (as defined in the Definitions Article) and could result in balance billing to you. Your least costs occur when you choose in-network providers.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*

Physician & Health Care Practitioner Services
 	
• Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, hospital, urgent care facility or other covered health care facility location. Payable Physician and Health Care Practitioner professional fees include:
  • Hospitalist physician under the Hospitalist Program, Surgeon, Assistant Surgeon (if Medically Necessary) and Certified Surgical Assistant (CSA)/Certified Surgical Technician (CST)
  • Anesthesia provided by Physician and Certified Registered Nurse Anesthetist ("CRNA")
  • Pathologist; Radiologist, and Podiatrist (DPM)
  • Physician Assistant (PA), Nurse Practitioner (NP), and Certified Nurse Midwife
  • Breastfeeding/Lactation Educator
Physician care by specialists such as an Obstetrician/Gynecologist ("OB/GYN") and a Pediatrician, will be payable for covered services, in a manner consistent with the payment rules outlined on this Schedule of Medical PPO Plan Benefits, since specialists are not part of the Hospitalist Program.
	• **Some Physician & Health Care Practitioner Services require precertification.** See the Utilization Review and Case Management Article for details on precertification requirements.
	• See also the Definition of "Physician," "Health Care Practitioner," and "Surgery" in the Definitions Article.
	• See the Quick Reference Chart for information about the **LiveHealth Online visit** service.
	• See the Quick Reference Chart for information about services provided at the **Family Wellness Centers without any cost**. See also the Family Wellness Centers (near-site health care clinics) row.
	• The Claims Administrator will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the Definition of "Surgery" in the Definitions Article.
	• **Assistant Surgeon** fees will be reimbursed only for Medically Necessary services to a maximum of 20% of the eligible expenses allowed for the Primary Surgeon. Services by a Certified Surgical Assistant (See Definition of "Certified Surgical Assistant" in the Definitions Article) are payable if the use of a Certified Assistant Surgeon was Medically Necessary.
	• **Anesthesia Services:** If both an Anesthesiologist Physician and a Certified Registered Nurse Anesthetist ("CRNA") bill the Plan for anesthesia services on the same procedure, the Plan will allow, as total payment, the amount that would have been payable had just one professional performed the anesthesia services. Plan payment will be split 50/50 between the Anesthesiologist and the CRNA.
	• **Primary Care Provider (PCP)** means a Physician (MD or DO) or other Health Care Practitioner who practices general medicine, family medicine, internal medicine, pediatrics or obstetrics/gynecology. All other Physicians are considered specialists under this Plan. Under this Medical PPO Plan, there is no requirement to select a PCP or to obtain a referral or prior authorization before visiting an OB/GYN provider.
	• **Routine Foot Care Benefit**: Routine foot care administered by a Podiatrist is payable when Medically Necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
	• Foot Care is payable when Medically Necessary for **symptomatic foot conditions** such as plantar fasciitis, bone spurs, hammertoes or bunions.
	• See also the Emergency Services row.
	• See also the Family Planning, Maternity, and Wellness rows where certain women's preventive services are payable without cost-sharing when obtained from in-network providers.
		Primary Care Provider (PCP) Office Visit: You pay a $50 copay per visit, after Deductible met.
		Specialist Office Visit: You pay a $65 copay per visit, after Deductible met.
		LiveHealth Online Visit: $10 copay/visit. Deductible does not apply.
		Office Visit at a Family Wellness Center clinic: No charge, no deductible.
		Inpatient Hospitalist Services: No charge, no deductible.
		Inpatient Visit by Specialist: $65 copay per visit (non-specialist provider: $50 copay/visit) after deductible met
		Assistant Surgeon: No charge after Deductible met.
		Anesthesia Services and Physician Obstetrical Care: $100 Copay after Deductible met
		Surgeon Fees: $250 copay per surgery after Deductible met
		Emergency Room Physician in an Emergency: No charge after Deductible met.
			After Deductible met the Plan pays 50% of allowable expenses.
			
			See also the Emergency Room row in this schedule.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Acupuncture Services	• Acupuncture is payable to a maximum of **15 visits** per person per Calendar Year.	You pay a $50 Copay per visit after the Deductible is met.	After Deductible met the Plan pays 50% of allowable expenses.
Allergy Services • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered only when ordered by a Physician. • Desensitization injections (allergy shots) are covered only when provided by a licensed Health Care Practitioner. • **RAST and MAST allergy testing requires precertification.** See the Utilization Review and Case Management Article for details on precertification requirements.	Testing or Allergy Shots (including Antigen): You pay a $65 Copay/visit after Deductible met.	Testing or Allergy Shots (including Antigen): Plan pays 50% of allowable expenses after deductible met.

Ambulance Services and Non-Emergency Medical Transport Services
• **Ground vehicle emergency transportation:**
  • to the nearest appropriate facility as Medically Necessary for treatment of a medical Emergency or acute illness;
  • for Medically Necessary inter-health care facility transfer (e.g. transfer from one hospital to another hospital or trip to and from one hospital to another in order to obtain a higher level of care).
• **Air/sea emergency transportation** only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status. **Air/sea ambulance transportation** is payable: (1) only when Medically Necessary for treatment of a life-threatening Emergency, and (2) the air/sea transport is required because of inaccessibility by ground transport and/or the use of ground transport would endanger the patient's health status. When air/sea ambulance transportation is required, it is payable **to the nearest acute health care facility qualified to treat the patient's emergency condition**.
• **Non-emergency medical transport** is payable, when precertified, as noted to the right.
	• Expenses for ambulance services are covered only when those services are for an **Emergency** as that term is defined in the Definitions Article of this document under the heading of "Emergency Care," or for Medically Necessary inter-facility transport.
	• Non-emergency medical transportation refers to transport of an individual in a vehicle because the individual cannot safely use public or private transportation due to his/her Medically Necessary requirement to be positioned in a wheelchair or stretcher, or because they require the use of certain medical equipment or non-emergency medical monitoring during transport.
	  • **Non-emergency medical transportation services are not payable by this Plan except when precertified by the UR Company**. See the Utilization Review and Case Management Article for details.
	  • When preapproved, the Plan may pay toward the least expensive and appropriate method of transportation that meets the physical and medical circumstances of the individual and the Plan reserves the right to limit its payment of transportation to the nearest appropriate location (such as the nearest provider of medical services when it has made a determination that traveling further distances provides no medical benefit to the individual).
		Ambulance: After Deductible met, you pay a $400 Copay per trip.
		Non-emergency medical transport: After Deductible met, you pay a $400 Copay per trip.
			Ambulance: After Deductible met, you pay a $400 Copay per trip.
			Non-emergency medical transport: After Deductible met, you pay a $400 Copay per trip.

Ambulatory Surgical Center	• See the Outpatient (Ambulatory) Surgery Facility row in this Schedule.		

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Autism Treatment, including Applied Behavioral Analysis (ABA) Therapy	• Prior Authorization is required • Treatment must be identified in a treatment plan that is prescribed by a licensed physician or licensed psychologist • Treatment must be provided by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by a licensed physician, psychologist or behavior analyst	**$50 Copay per visit**	**Not Covered**
Behavioral Health Services **(Mental Health and Substance Use Treatment)** • Employee Assistance Program (EAP) Services: This plan offers up to **eight (8) free EAP visits for professional confidential counseling**. The phone number for the EAP program is listed on the Quick Reference Chart in the front of this document. The EAP visits can be used for smoking cessation therapy. In addition to the EAP services the following benefits are available: • **Outpatient services:** outpatient visits and other outpatient services (including intensive outpatient program (IOP), and partial day treatment/hospitalization). Partial day treatment/hospitalization means treatment of mental, nervous, or emotional disorders and substance use for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period. • **Inpatient acute hospital admission and residential treatment program.** • **Residential treatment program and halfway house payable same as an inpatient admission**.	• **Elective inpatient Behavioral Health admission and residential treatment program admission requires precertification** by calling the Behavioral Health Program whose contact information is listed on the Quick Reference Chart in the front of this document. • **For help finding a provider qualified to assist you with your outpatient counseling needs, please contact** the Behavioral Health Program whose contact information is listed on the Quick Reference Chart in the front of this document. • Outpatient prescription drugs for Behavioral Health payable under Drugs in this Schedule of Medical PPO Plan Benefits. • Coverage is provided for the diagnosis and treatment of autism spectrum disorders. See Autism Treatment, including Applied Behavioral Analysis (ABA) Therapy row in this Schedule. • See the specific Exclusions related to Behavioral Health Services, in the Medical PPO Plan Exclusions Article. Benefits are payable only for services of Behavioral Health Care Practitioners listed in the Definitions Article.	**EAP Counseling (up to 8 visits):** No charge **Outpatient Visits and Other Outpatient Services:** After Deductible met, $35 copay per visit **Inpatient Admission and Residential Treatment Program:** After the Deductible Is met there is an additional **$300 copay for the first day, then $150 copay per day following** up to the $1,500 coinsurance/copay limit per admission. **LiveHealth Online Visit:** $10 copay/visit. Deductible does not apply.	**Outpatient Services:** After Deductible met the Plan pays 50% of allowable expenses. **Residential Treatment Program:** Not covered. **Inpatient Admission:** After the Deductible is met there is an additional **$1,000 Inpatient Copay** per admission then the member is responsible for 50% coinsurance (Plan pays 50% of allowable expenses) up to the coinsurance/copay limit. **Reminder,** Out-of-Network providers are paid according to the Allowable Expense (as defined in the Definitions Article) and could result in balance billing to you. Your least cost occurs when you choose in-network providers.
Birthing Center/Facility	• See the Maternity Services row of this Schedule.		

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Blood Transfusions Blood transfusions and blood products and equipment for its administration.	• Covered only when ordered by a Physician.	$100 copay per visit after deductible is met .	After Deductible met the Plan pays 50% of allowable expenses.
Chemotherapy • Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Covered only when ordered by a Physician.	After Deductible met, $65 Copay per visit, plus $50 copay/visit for chemotherapy drugs.	After Deductible met the Plan pays 50% of allowable expenses.
Chiropractic Services	• See the Spinal Manipulation section of this Schedule of Medical PPO Plan Benefits.		

Corrective Appliances (Prosthetic & Orthotic Devices, other than Dental)
• Coverage is provided for Medically Necessary Prosthetic and Orthotic devices as follows:
  • rental (but only up to the allowed purchase price of the device).
  • purchase of standard model.
  • repair, adjustment or servicing of the device as is Medically Necessary.
  • replacement of the device is payable if there is a change in the covered person's physical condition making the current device inoperable or unsatisfactory in order to perform normal daily activities (as certified by the patient's Physician), or if the device cannot be satisfactorily repaired.
• Corrective Appliances are covered only when ordered by a Physician or Health Care Practitioner.
• Colostomy, ostomy and/or urinary catheter supplies.
• Cranial remodeling bands and helmets (orthotic devices) are covered for the treatment of head deformities in Children.
	• See the Exclusions related to Corrective Appliances in the Medical PPO Plan Exclusions Article. To help determine what Prosthetic or Orthotic Appliances are covered, see the Definitions of "Prosthetics" and "Orthotics" in the Definitions Article.
	• An initial pair of eyeglasses is payable under this medical plan following surgery to remove the lens of the eye (such as with a cataract extraction).
	• **Non-foot related Orthotic devices** are payable when medically necessary, such as a knee brace.
	• **Foot Orthotics** (orthopedic or corrective shoe supportive appliances for the feet) are payable to a maximum of $500 every 5 years. Replacement foot orthotics are payable once every 60 months for adults, and once every three years for Children. No coverage for orthopedic or corrective shoes.
	• Compression stockings: anti-embolism, surgical compression, vascular support garments/stockings (*e.g.* Jobst) payable up to 3 pairs every 6 months not to exceed 6 pairs per year.
	• **Implantable hearing aids** such as cochlear implants are payable for Participants who meet certain criteria, such as all of the following criteria:
	  a. the **procedure is precertified** as Medically Necessary according to the Plan's Utilization Review and Case Management firm. See the Utilization Review and Case Management Article for details;
	  b. the hearing device is not experimental; and
	  c. payable only when provided by In-Network Health Care Providers
	• Replacement speech processors and other external parts associated with implantable hearing devices are payable when determined to be Medically Necessary by the Board of Trustees or its designee because the existing device cannot be repaired or, replacement is required because a change in the person's physical condition makes the present unit non-functional and significant improvement is expected with a replacement unit.
		Prosthetic Devices and all Orthotic Devices: $50 copay per device after deductible met.
		
		Medical Supplies to operate Prosthetic and Orthotic Devices: No charge.
			After Deductible met the Plan pays 50% of allowable expenses.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Diabetes Education	• Coverage is payable for a formal diabetes education course/program taught by a Certified Diabetes Educator and recognized as an acceptable program by the American Diabetes Association. A diabetes education program is payable when a person is initially diagnosed with diabetes. See also the dietitian benefit in this Schedule for assistance learning the foods to eat to help control blood sugar.	No charge	Not covered.
Dialysis • Hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.	• Benefit payments may vary depending on the location in which the hemodialysis or peritoneal dialysis is performed or received by the patient. • **It is important that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age**. See also the Coordination of Benefits Article that discusses what this Plan pays when you are also Medicare eligible.	Outpatient Dialysis: $65 Copay/visit, after deductible met.	**No coverage** except for an emergency dialysis treatment to stabilize a patient for transfer to an In-Network dialysis provider.
Dietitian Services	• Benefits are payable for Dietary counseling to assist individuals with their nutritional health and dietary needs. Services can be used for assistance with food choices when diagnosed with such diseases as high blood pressure, cardiac disease, diabetes, high cholesterol, allergies, kidney disease, etc. This dietary counseling is payable as a Wellness service in accordance with Health Reform requirements. Services of a Registered Dietitian or licensed or certified Nutritionist are **payable to a maximum of five (5) visits per person per Calendar Year**. This visit limit does not apply to nutritional counseling services that are medically necessary for the treatment of an individual diagnosed with a mental health or substance use condition, such as an eating disorder. Certain dietary counseling may be payable as a Wellness service in accordance with Health Reform requirements. • Benefits are available from in-network providers only.	No charge.	Not covered.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*

Drugs (Outpatient Retail/Mail Order Medicines)
• Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the FDA as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them.
• Coverage is also provided for prenatal vitamins; drugs required to be covered due to Health Reform, FDA approved female contraceptives, insulin, diabetic supplies (including blood glucose meter and testing supplies such as lancets, test strips, and syringes), self-administered injectables such as Epipen and Glucagon.
• Contact the Prescription Drug Program administrator (whose phone number is listed on the Quick Reference Chart in the front of this document) for the following:
  • The list of drugs on the **Preferred Drug Formulary**.
  • Information on **drugs needing preapproval** by the clinical staff of the Prescription Benefit Manager (PBM) (e.g. certain pain medication, allergy treatment, hormone therapy, seizure and headache drugs, Advair, allergy medication, depression treatment drugs).
  • Information on which **drugs have a limit to the quantity** payable by this Plan (e.g. drugs to treat erectile dysfunction, ADHD, migraine, certain hormone therapy).
  • Information on which drugs are part of the **step therapy program** where you first try a proven, cost-effective medication before moving to a more costly drug treatment option. Step therapy drugs include GERD/ulcer treatment, statins for cholesterol, Cox 2 inhibitors like Celebrex or Vioxx, certain depression treatment drugs, Advair, nail fungus treatment, calcium channel blockers like Verapamil, allergy treatment and statins to treat high cholesterol/lipids.
Specialty drugs are available on an outpatient basis when ordered through and managed by the Prescription Benefit Manager (PBM). Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis or hepatitis. These drugs may need precertification, often require special handling, are date sensitive, and are generally available only in a 30-day supply.
	The Prescription Drug Program: Benefits for prescription drugs are provided through the Plan's Prescription Benefit Manager (PBM) whose name is listed on the Quick Reference Chart in the front of this document.
	• **Retail Drugs**: To obtain up to a 30-day supply of medicine, for the cost-sharing noted to the right, present your ID card to any In-Network retail pharmacy. Contact the Prescription Benefit Manager (PBM) (whose name is listed on the Quick Reference Chart) for the location of In-Network retail pharmacies.
	• **Mail Order (Home Delivery) Drug Service:** The mail order service is the easiest and least expensive way to obtain many drugs, plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure, arthritis or diabetes. Note that not all medicines are available via mail order. Check with the Prescription Benefit Manager (PBM) for further information. To use the mail order service:
	  a) Have your doctor write the prescription for a 90-day supply, with the appropriate refills.
	  b) Mail your prescription, Copay, and the mail order form to the Mail Order Services of the Prescription Benefit Manager (PBM) whose address is listed on the Quick Reference Chart. Mail order forms may be obtained from the Prescription Benefit Manager (PBM). Allow up to 14 days to receive your order.
	• **There is no coverage or reimbursement for drugs that you obtain at an Out-of-Network Retail Pharmacy.**
	• Note that if the cost of the drug is less than the Copay/Coinsurance you pay just the drug cost.
	• The Plan provides a **mandatory generic program** meaning that if a brand name drug is dispensed in place of a generic, regardless if you or your doctor request it, you will pay the brand cost-sharing plus the difference in cost between the generic and brand name drug.
	• **FDA-approved contraceptives for females:** covered at 100%, no cost-sharing for generic drugs submitted with a physician prescription purchased at an In-network Retail or Mail Order location. No charge for brand prescription contraceptive drugs only if a generic contraceptive is unavailable or medically inappropriate. No coverage from a Non-Network/Out-of-Network retail pharmacy.
	• In accordance with Health Reform, certain **over-the-counter (OTC) and prescription drugs** are payable at no charge when prescribed by a Physician or Health Care Practitioner (see page 28 for details).
	• Drugs not yet approved by the FDA are not covered. New FDA approved drugs will not be covered until a clinical review and formulary placement has been made by the Prescription Benefit Manager (PBM).
	• Certain CDC recommended **vaccinations** are payable at 100%, no cost-sharing when obtained at an in-network retail pharmacy. Contact the Prescription Benefit Manager for more information.
	• See also the Exclusions related to Drugs (Medicines) in the Medical PPO Plan Exclusions Article.
	• **Testosterone therapy for males requires prior authorization** by the Prescription Drug Program when diagnosed with clinically significant hypogonadism.
	• See the Quick Reference Chart for information about certain prescription drugs dispensed at **Family Wellness Centers at no cost**. See also the Family Wellness Centers (near-site health care clinics) row.
	See the Out-of-Pocket Limit row in this Schedule for information on the amount of the annual Out-of-Pocket Limit for outpatient drugs.
		No Deductible applies to outpatient drugs.
		
		In-Network Retail Pharmacy and Specialty Drugs (up to a 30-day supply):
		Generic: $25 Copay.
		Preferred Brand: $50 Copay.
		Non-Preferred Brand: $75 Copay.
		Specialty Drugs: $100 Copay.
		Certain generic drugs dispensed at Family Wellness Center clinics: No charge
		
		Diabetic Supplies: No charge.
		
		Female Contraceptives: No charge for generic drugs.
		
		Mail Order Service (up to a 90-day supply):
		Generic: $50 Copay.
		Preferred Brand: $100 Copay.
		Non-Preferred Brand: $150 Copay.
		Specialty: $200 Copay.
			Retail drugs are only available In-Network.
			
			No coverage for drugs obtained out-of-network.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
• **Drugs (Other Outpatient Setting such as in the Home or Doctor Office)**	• For Intramuscular (IM) or Intravenous (IV) drugs administered in an outpatient setting (other than when obtained via Retail or Mail Order) **when the cost of the drug is MORE THAN $500**.	For drug: After deductible met, $100 copay per day.	For drug: After Deductible met the Plan pays 50% of allowable expenses.

Durable Medical Equipment (DME)
• Coverage is provided for:
  • rental (but only up to the allowed purchase price of the Durable Medical Equipment);
  • purchase of standard model equipment;
  • repair, adjustment or servicing of Medically Necessary DME is payable.
  • replacement of Medically Necessary Durable Medical Equipment is covered only if there is a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired at a lesser expense.
  • supplies that are necessary for the function of the durable medical equipment are also covered so long as the equipment is medically necessary for the individual who is covered under this Plan.
• Coverage is provided for Medically Necessary oxygen, along with the Medically Necessary equipment and supplies required for its administration.
• Coverage is provided for diabetic glucose meter and other medically necessary diabetes durable medical equipment.
	• **Durable Medical Equipment (DME) over $500 per item requires precertification.** See the Utilization Review and Case Management Article for details.
	• To help determine what Durable Medical Equipment is covered, see the Definition of "Durable Medical Equipment" in the Definitions Article.
	• Durable Medical Equipment (and supplies necessary for the function of the durable medical equipment) is covered only when its use is Medically Necessary and it is ordered by a Physician or Health Care Practitioner.
	• Durable Medical Equipment: the benefits provided here are limited to meet your basic needs. Expenses for equipment options in excess of the basic equipment are your financial responsibility. The Plan will not pay for equipment or devices not specifically designed and intended for the care and treatment of a covered injury or illness.
	• For females who are breastfeeding, coverage is provided for one standard manual or standard electric breast pump (not hospital grade), plus supplies necessary to operate the breast pump. Rental, purchase and repair is payable as outlined to the left. Coverage is available at no cost from in-network providers only. Standard cost-sharing applies to use of non-network providers.
	• Rental of oxygen requires a written statement of continued necessity from the Physician to be submitted to the Administrative Office every 6 months.
	• See the Exclusions related to Corrective Appliances and Durable Medical Equipment in the Medical PPO Plan Exclusions Article.
		Breast pump and supplies: No charge.
		All other DME: After deductible met you pay a $50 Copay per device.
		Medical Supplies to Operate DME: No charge.
			After Deductible met the Plan pays 50% of allowable expenses.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Emergency Room Facility, Urgent Care Facility • Hospital emergency room (ER) or "Nonparticipating Emergency Facility" for "emergency services" (as those terms are defined in this Plan). • Urgent Care facility. Common medical conditions that may be appropriate for a Physician office or Urgent Care facility (instead of an Emergency Room) include, but are not limited to, fever, sore throat, earache, cough, flu symptoms, sprains, bone or joint injuries, diarrhea or vomiting, or bladder infection. • Ancillary charges (such as lab or x-ray) performed during the ER or Urgent care visit. • (See also the Ambulance section of this schedule.)	• See also the Definition of "Emergency Care" in the Definitions Article. • The ER visit Copayment will be waived if you are subsequently and immediately Hospitalized. • **IMPORTANT NOTE: For non-emergency but Medically Necessary services received in an emergency room the Plan pays a maximum of $75 per visit, including all related services.** • There is no requirement to precertify (obtain prior authorization) for the use of a hospital-based emergency room visit or an independent freestanding emergency department visit. • See the Definition of "Allowable Expense" or contact the Administrative Office for more details on what the Plan allows as payment to Out-of-Network emergency service providers. • See the Quick Reference Chart for information about urgent care services provided at **Family Wellness Centers at no cost**. See also the Family Wellness Centers (near-site health care clinics) row.	**Emergency Services in an Emergency Room**: After Deductible met, you pay a $250 Copay/visit. **Emergency Room Physician for Emergency Services:** After Deductible met, no charge. **Urgent Care Facility**: After Deductible met, you pay a $100 Copay/visit. **Urgent Care services at a Family Wellness Center clinic**: No charge. **Non-emergency services in an Emergency Room:** The most the Plan pays is up to $75 maximum per visit including all related services. Deductible applies.	**Emergency Services in an Emergency Room**: After Deductible met, you pay a $250 Copay/visit. **Emergency Room Physician for Emergency Services:** After Deductible met, no charge. **Urgent Care Facility**: After Deductible met the Plan pays 50% of allowable expenses. **Non-emergency services in an Emergency Room:** The most the Plan pays is up to $75 maximum per visit including all related services. Deductible applies.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*

Enteral Therapy Services
• Enteral nutritional therapy provides nourishment directly (e.g. feeding tube) to the digestive tract of a person who cannot ingest an appropriate amount of calories and nutrients to maintain an acceptable nutritional status.
• Enteral nutritional formula is payable when medically necessary **and precertified** and meets all the following criteria:
  • When the formula is the primary source of nutrition (i.e., 60% or more of caloric nutritional intake) and ALL of the following criteria are met:
  a. Without enteral feedings, the individual would be unable to obtain sufficient nutrients to maintain an appropriate weight by dietary adjustment and/or oral supplements, and
  b. The individual has one of the following conditions that is expected to be permanent or of indefinite duration:
  • an anatomical or motility disorder of the gastrointestinal tract that prevents food from reaching the small bowel;
  • disease of the small bowel that impairs absorption of an oral diet;
  • a central nervous; or system/neuromuscular condition that significantly impairs the ability to safely ingest oral nutrition.
	• Enteral therapy services are covered only when ordered by a Physician.
	• **Enteral Therapy Services require precertification.** See the Utilization Review and Case Management Article for details.
	• Coverage for a home enteral infusion pump (and associated necessary supplies) is considered payable when the use of the pump is medically necessary because the individual cannot tolerate gravity or syringe feedings or requires a controlled rate of infusion of the enteral formula.
	• Enteral nutritional formula that is **not payable** by the Plan includes:
	  • standardized or specialized infant formula (e.g., Alimentum, Elecare, Neocate, and Nutramigen), or baby food for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-sensitivity, or formula for protein, soy or fat digestive problems.
	  • food thickeners, dietary and food supplements including but not limited to puddings, powders, mixes, vitamins and minerals; lactose-free products or products to aid in lactose digestion, gluten-free food products, high protein or high carbohydrate products and the like.
	  • weight-loss or weight-gain foods, formulas or products; normal grocery items, low carbohydrate foods, nutritional supplement puddings, powders, mixes, vitamins and mineral.
		Infusion pump:
		You pay a $50 Copay after Deductible met.
		
		Home health visits:
		You pay a $50 Copay per visit after Deductible is met.
			After Deductible met the Plan pays 50% of allowable expenses.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Family Planning, Reproductive, and Contraceptive Services • **Sterilization services** (e.g., vasectomy, tubal ligation, implants such as Essure). In accordance with Health Reform, there is no cost-sharing for female sterilization when performed by in-network providers. • **FDA-approved contraceptives for females**, such as oral birth control pills/patch, emergency contraception, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD), cervical cap, contraceptive ring, diaphragm, implantable birth control device/service (e.g. Implanon). See also the Drug row of this Schedule for information on no cost-sharing for FDA-approved female contraceptives. • Prescription drug treatment of erectile dysfunction (impotency) (e.g., Cialis, Viagra) is payable under the Prescription Drug Program as noted on the Drug row of this schedule.	• For maternity coverage see the Maternity row in this schedule. • Plan covers replacement of IUD's in accordance with FDA requirements. • See the specific Exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Erectile Dysfunction Services in the Medical PPO Plan Exclusions Article. • The Plan covers an initial visit and diagnostic tests to determine if a person is infertile. **No coverage for fertility/infertility services or for reversal of sterilization procedures**.	**FDA approved Female Contraceptives and Female sterilization procedures**: No charge. **Vasectomy:** $250 Copay per visit, after Deductible met. For other services, see the Physician services row of this Schedule.	After Deductible met the Plan pays 50% of allowable expenses.
Family Wellness Centers (Near site health care clinics) • Local, convenient access to medical care and prescription drugs for Medical PPO Plan Participants without any **out-of-pocket costs.** Services include: Primary care and Urgent care Routine physicals and preventive care Basic diagnostic and laboratory services Wellness programs and lifestyle improvement Health coaching and risk assessments Chronic condition/disease management Access to 50-75 generic prescription drugs dispensed onsite	See the Quick Reference Chart for information about the Family Wellness Centers provided by Activate Healthcare. Clinics are staffed with licensed physicians, advanced practitioners, and medical assistants to provide quality care.	No charge. Deductible does not apply.	Not covered.
Gene Therapy (Human) A technique designed to introduce human genetic material into human cells to compensate for abnormal genes or to make a beneficial protein. Gene therapy is, used to treat or prevent disease in humans by genetically altering the patient's cells to fight their disease.	• **Gene therapy services require precertification** (to avoid non-payment) by calling the UM Company whose contact information is listed on the Quick Reference Chart in the front of this document. See also the definition of Gene Therapy in the Definitions chapter.	See the Hospital and Physician services rows of this Schedule.	See the Hospital and Physician services rows of this Schedule.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*

Genetic Testing and Counseling
 	
Genetic testing that is consistent with Health Reform law is currently covered at no cost when in-network providers are used. Effective July 1, 2013, the genetic testing payable under this Plan will include:
• genetic testing (e.g. BRCA, stool DNA such as Cologuard) and genetic counseling as a Preventive service (see the Wellness row in this Schedule).
• state-mandated newborn screening tests for genetic disorders (referred to as surrogate biochemical markers);
• fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Board of Trustees or its designee;
• tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity;
• the genetic testing as recommended by the American College of Obstetrics and Gynecology for pregnant women such as genetic carrier testing for cystic fibrosis;
• the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered Participants who have all the following:
  • the testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and
  • the covered individual displays clinical features/symptoms, or is at direct risk of developing the genetically linked heritable disease/condition in question (pre-symptomatic); and
  • the results of the test will directly impact the clinical decision-making, clinical outcome or treatment being delivered to the covered individual.
• **Genetic Counseling** is payable when ordered by a Physician, performed by a qualified Genetic Counselor and provided in conjunction with a genetic test that is payable by this Plan.
	• See the Definitions of Genetic Counseling, Genetic Testing in the Definitions Article.
	• See the Medical PPO Plan Exclusions Article for Exclusions relating to Genetic Testing and Counseling.
	• Plan Participants should **use the Plan's precertification procedure or contact the Administrative Office for assistance determining if a proposed genetic test will be covered or excluded**.
		Genetic tests & counseling consistent with Health Reform law: No charge.
		
		All other covered genetic testing: $65 Copay per test, after Deductible met.
		
		All other covered genetic counseling: $65 Copay per visit after Deductible met.
			After Deductible met the Plan pays 50% of allowable expenses.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Hearing Services • An audiology (audiometry) hearing exam is payable.	• Hearing services are covered only when ordered by a Physician. • There is a separate **$50 Copay** for the purchase of an external hearing aid in addition to the usual medical plan Deductible. • An external **Hearing aid is payable up to $600 per ear** (this is payable once every five (5) years for adults and once every three (3) years for a Child). See the Corrective Appliances row for information on coverage of an implantable hearing aid. • No coverage for: cleaning, repair or maintenance of a hearing aid, batteries, replacement of lost, stolen or broken hearing aids for which payment was made under this benefit; more than one hearing aid for each ear during the timeframes noted above.	**Audiology Exam:** After the medical plan deductible is met, you pay a $65 Copay/visit. **External Hearing Aid:** After the medical plan deductible and the separate $50 hearing aid Copay is met, the Plan pays 90%.	After Deductible met then Plan pays 50% of allowable expenses.
Home Health Care and Home Infusion Therapy Services • Part-time, intermittent **Skilled Nursing Care** services (performed by a registered nurse or licensed vocational nurse supervised by an RN) and Medically Necessary supplies to provide Home Health Care or home infusion services. See also the Definition of Infusion Therapy in the Definitions Article. • **Home services other than Skilled Nursing Care are not covered.**	• **Home health and home infusion therapy services require precertification.** See the Utilization Review and Case Management Article for details. • Home Health Care and Home Infusion services are covered only when ordered by a Physician or Health Care Practitioner and provided by a licensed home health care agency. • Home Hospice coverage is payable under Hospice Benefits. • Home Physical, Speech or Occupational Therapy services coverage is payable under the Rehabilitation Services Benefits. • No coverage for part-time or intermittent home health aides except when provide during a covered home hospice program. • No coverage for custodial care or 24-hour private duty nursing care. See the Exclusions related to Home Health Care and Custodial Care (including personal care and Child care) in the Medical PPO Plan Exclusions Article of this document.	After Deductible met, you pay $50 Copay/visit	After Deductible met then Plan pays 50% of allowable expenses.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Hospice • Hospice services include inpatient hospice care and outpatient home hospice when the patient meets the Definition of hospice in the Definitions Article of this document.	• Covered only when ordered by a Physician. • Bereavement counseling through the Hospice program must be completed within 6 months of the date of death. Bereavement counseling beyond that which is included as part of the Hospice program is payable under the Behavioral Health Benefits of this Plan. • If transferred directly from a hospital, the hospital admission copay is waived. • Home health aides are covered only when part of a covered home hospice program.	**Home Hospice services:** After Deductible met, you pay a $50 Copay/visit. **Bereavement Counseling:** After Deductible met, you pay a $35 Copay/visit. **Inpatient Hospice services:** After Deductible met there is an additional $ $300 copay for the first day, then $150 copay per day following up to the $1,500 coinsurance/copay limit per admission,.	**Home Hospice services and Bereavement Counseling:** After Deductible met the Plan pays 50% of allowable expenses. **Inpatient Hospice services:** Not covered. **Reminder,** Out-of-Network providers are paid according to the Allowable Expense (as defined in the Definitions Article) and could result in balance billing to you. Your least costs occur when you choose in-network providers.
Hyperbaric Oxygen Treatment	• Covered only when ordered by a Physician or Health Care Practitioner. • **Hyperbaric Oxygen Therapy services require precertification** by calling the appropriate UM Company (whose contact information is listed on the Contact Information Chart in the front of this document). See the Utilization Review and Case Management Article for details.	$65 copay	After Deductible met the Plan pays 50% of allowable expenses.
Laboratory Services (Outpatient) • Technical and professional fees. • Some laboratory services are payable under the Wellness Benefits in this Schedule.	• Covered only when ordered by a Physician or Health Care Practitioner. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical PPO Plan Benefits. • No coverage for a sleep study or neuro-monitoring test performed by an out-of-network provider.	After Deductible met, you pay a $25 Copay per visit. Sleep studies: After Deductible met, you pay a $65 Copay per visit.	After Deductible met the Plan pays 50% of allowable expenses.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Maternity Services • Plan covers Hospital, Birth (Birthing) Center charges and professional fees for a Physician and Certified Nurse Midwife for Medically Necessary maternity services. • See the Hospital row for payment of hospital or birthing center. See the Physician row for payment of professional fees. See Genetic Testing for additional information. See the Family Planning row and Drug row for information on contraceptive coverage. • See the Eligibility Article on how to enroll a Newborn Dependent Child(ren). • Breastfeeding equipment (breast pump) and supplies necessary to operate the pump are payable as noted on the Durable Medical Equipment row of this Schedule. • The Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) while breastfeeding, at 100%, no Deductible, when provided by an in-network provider acting within the scope of his/her license including a Breastfeeding/Lactation Educator, as defined in the Definitions Article. • You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.	• **The Plan does not pay for expenses related to the maternity care and delivery expenses associated with a pregnant Dependent Child.** This exclusion of maternity care for a pregnant Dependent Child **does not apply to the extent the expenses qualify as prenatal and postnatal office visits,** but the **exclusion does apply to** maternity services that are not office visits and not consistent with ACA-mandated services such as ultrasounds.. • Certain prenatal care/maternity related preventive care expenses listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits are payable for all females, including but not limited to routine prenatal obstetrical office visits, screening for gestational diabetes, HPV testing starting at age 30, breastfeeding equipment and supplies to operate a pump, and lactation support and counseling by a trained provider These services are covered without cost sharing for a female when obtained from in-network providers. • Prenatal services not covered under the women's preventive/wellness coverage include, but are not limited to lab & radiology services, delivery and high-risk prenatal services. While obstetrical ultrasounds may be part of routine prenatal care, a Copayment, Coinsurance or Deductible may apply for these services. For all females, prenatal and postnatal visits obtained from an in-network provider are payable at no cost to you. Normal plan cost-sharing still applies to all other maternity related services including ultrasounds and delivery fees. • When an in-network provider submits a bill to the plan with a global CPT code for the combination of prenatal/postnatal visits and delivery expenses, the Plan's claims administrator will process the claim applying no cost-sharing to 40% of the charges representing the prenatal/postnatal visit expenses, and normal cost-sharing to 60% of the charges representing the delivery expenses. • Pregnancy-related care is covered for a female Retiree, or Spouse only. No coverage is provided for certain maternity or delivery expenses of Dependent Children. This exclusion of maternity care for a pregnant Dependent Child does not apply to prenatal and postnatal care office visits and certain other preventive screening services consistent with health reform such as breast pump and supplies needed to operate the pump and lactation counseling. No coverage for ultrasounds and other pregnancy related services or delivery expenses for the pregnant Dependent Child and their baby. • **Hospital Length of Stay for Childbirth:** Under federal law, group health plans, like this Plan, generally may not restrict Benefits for any hospital length of stay in connection with Childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). **However, for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact the UR Company to precertify the extended stay.** For information on precertification, refer to the Utilization Review and Case Management Article in this document. • **Elective induced abortion** is not covered, except when the attending Physician certifies that the woman's health would be endangered if the fetus were carried to term, or where medical complications arise from an abortion Expenses related to a pre-planned home birth are not payable. See the Exclusions related to Maternity Services in the Medical PPO Plan Exclusions Article.	**Prenatal and postnatal office visits and services consistent with Health Reform:** No charge. **Breastfeeding equipment and supplies:** No charge. **Lactation counseling:** No charge. For delivery fees: refer to the physician and hospital rows of this schedule.	After Deductible met the Plan pays 50% of allowable expenses.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Mayo Clinic Complex Care Program	• Cost-sharing (e.g. deductible, coinsurance, and copays) would be reduced to $0 and 0% for care received at Mayo Clinic in connection with the Mayo Clinic Complex Care Program referral. • Experimental or investigational does not include services when recommended by the Mayo Clinic and received when participating in the Mayo Clinic Complex Care Program. • Proton Beam Therapy is covered if recommended by and provided at any Mayo Clinic location. • You must obtain authorization for services received in the Mayo Clinic Complex Care Program by contacting both the Clinical Director (at the Administrative Office) and the Utilization Management Company. • Precertification and/or prior authorization requirement is waived for Mayo Clinic when receiving care through the Mayo Clinic Complex Care Program. • Travel expenses and lodging expenses up to allowable limits as provided by law when participants use the Mayo Clinic Complex Care Program benefit.		

Nondurable Medical Supplies
• Coverage is provided for Medically Necessary nondurable supplies dispensed and used by a Physician or Health Care Practitioner in conjunction with treatment of the covered individual.
• Coverage is provided for up to a 31-day supply of Medically Necessary home/personal use:
  • Sterile surgical supplies used immediately after surgery.
  • Supplies needed to operate or use covered Durable Medical Equipment or Corrective Appliances.
  • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.
  • Dialysis supplies.
  • Colostomy and ostomy supplies.
• Diabetic supplies (e.g., insulin syringes, test strips, lancets, alcohol swabs) are covered.
	• To determine what Nondurable Medical Supplies are covered, see the Definition of "Nondurable Supplies" in the Definitions Article.
	• **Nondurable medical supplies needed for more than a 6-month period require precertification.** See the Utilization Review and Case Management Article for details.
	•
		No charge	After Deductible met the Plan pays 50% of allowable expenses.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*

Oral, Craniofacial, and TMJ Services
• Accidental Injury to Teeth/Jaw
• Temporomandibular Joint (TMJ) dysfunction or syndrome
• Medically necessary Temporomandibular Joint (TMJ) diseases and injury not related to TMJ dysfunction or syndrome
• Oral and/or Craniofacial Surgery.
• Charges by an oral maxillofacial surgeon for reduction of a facial bone fractures, removal of jaw tumors, treatment of jaw dislocations, treatment of facial and oral wounds or lacerations or infections (cellulitis), and removal of cysts or tumors of the jaws/facial bones. See also the Exclusions related to Dental Services in the Medical PPO Plan Exclusions Article.
	• Treatment of Temporomandibular Joint (TMJ) dysfunction or syndrome (including surgery) is payable up to $4,000 per person per lifetime.
	• Treatment of Accidental Injuries to the Teeth: This medical plan will pay for treatment of certain accidental injuries to the teeth and jaws when, in the opinion of the Board of Trustees or its designee, all of the following conditions are met:
	  • The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and
	  • The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and
	  • The dental treatment will return the person's teeth to their pre-injury level of health and function. The dental treatment provider is encouraged to seek pre-treatment approval from the Board of Trustees for dental work.
	  • Under this Plan, approved dental treatment is payable under the Medical Plan without regard to whether there is also associated Dental Plan coverage.
	  • See also the Definition of Injury to Teeth in the Definitions Article of this document.
	• Oral or craniofacial surgery is limited to cutting procedures to remove tumors, cysts, abscess, acute injury and for reconstructive but not cosmetic purposes.
	• No coverage for dental services such as removal of teeth including wisdom teeth, endodontics such as root canal, gingivectomy, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement) or orthognathic surgery for treatment of aesthetic malposition of the bones of the jaw.
	• See also the Exclusions related to Dental Services in the Medical PPO Plan Exclusions Article.
		Treatment of Temporo-mandibular Joint (TMJ) dysfunction or syndrome: After Deductible met Plan pays 50%.
		
		Other Physician services payable according to the Physician services row of this Schedule.
			Treatment of Temporo-mandibular Joint (TMJ) dysfunction or syndrome: After Deductible met Plan pays 50% of allowable expenses.
			
			Other Physician services payable according to the Physician services row of this Schedule.

Outpatient (Ambulatory) Surgery Facility/Center
• Ambulatory (Outpatient) Surgical Facility (e.g. surgicenter, same day surgery, outpatient surgery).
• Physician fees payable under the Physician services section of this Schedule of Medical PPO Plan Benefits.
	• **All Elective Surgery to be performed in a Hospital-based outpatient surgery center or free-standing Ambulatory Surgical Facility/Center requires precertification.** See the Utilization Review and Case Management Article for details.
	• Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by the Dental Plan if the Utilization Review and Case Management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services.
	  • No payment is extended toward the associated dental professional fee services provided while at a hospital or outpatient surgery facility.
	  • **Planned use of a hospital or outpatient surgery facility for a Dental purpose requires precertification.** See the Utilization Review and Case Management Article for details.
		Facility Charges: After Deductible met you pay a $250 facility Copay per visit.
		
		See the Physician row for payment of Physician professional fees.
			Not covered.

• **Prosthetic and Orthopedic Devices**	• See the Corrective Appliance row in this Schedule.		

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Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient) • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered only when ordered by a Physician or Health Care Practitioner. • **These diagnostic tests: MRI, CT scan, PET scan, MRA, CT angiography, and diagnostic tests billed over $500 require precertification.** See the Utilization Review and Case Management Article for details. • **Some Radiology procedures are covered at no charge as Wellness/Preventive services**. See the Wellness row in this Schedule. • A Therapeutic Radiology treatment is often referred to as Radiation Therapy.	**Therapeutic Radiology:** After Deductible met, you pay $65 Copay per day. **PPO Provider:** After Deductible met you pay $30 Copay per visit or $100 Copay per complex diagnostic test like MRI, MRA, CT, PET scan or angiogram).	After Deductible met the Plan pays 50% of allowable expenses.
Reconstructive Services and Breast Reconstruction After Mastectomy This Plan is not required to comply with the **Women's Health and Cancer Rights Act** (WHCRA). However, covered individuals who are receiving Benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including: • reconstruction of the breast on which the mastectomy was performed; • surgery and reconstruction of the other breast to produce a symmetrical appearance; and • prostheses and physical complications for all stages of mastectomy, including lymphedemas. These benefits are covered applying the same cost-sharing as is relevant to other medical/surgical plan benefits. • Reconstructive Surgery only if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, congenital or developmental anomaly that causes a functional defect. • Cranial remodeling bands and helmets are covered for the treatment of head deformities in Children.	• The Plan covers replacement external breast prostheses and mastectomy bras when medically necessary. • See the Exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Medical PPO Plan Exclusions Article. Most Cosmetic and Dental (including Orthognathic) services are excluded from coverage.	See the Hospital row and Physician row for payment information	See the Hospital row and Physician row for payment information

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Rehabilitation Services (Cardiac and Pulmonary) • **Cardiac Rehabilitation** is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.) with or without percutaneous transluminal coronary angioplasty (PTCA). • **Pulmonary Rehabilitation** is available to those individuals with a chronic respiratory disorder (e.g. emphysema, COPD) who are able to actively participate in a Pulmonary Rehabilitation program that is likely to improve their respiratory condition, as determined by the Board of Trustees or its designee.	• Cardiac and/or Pulmonary Rehabilitation programs must be ordered by a Physician. • See also the Definition of Cardiac Rehabilitation and Pulmonary Rehabilitation in the Definitions Article of this document.	After Deductible met, you pay a $50 Copay per visit.	After Deductible met the Plan pays 50% of allowable expenses.
Rehabilitation Services (Physical, Occupational & Speech Therapy) • Short term **active**, **progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician. • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active**, **progressive** Rehabilitation Services **that cannot be provided in an outpatient or home setting.**	• Rehabilitation services are covered only when ordered by a Physician. • **Inpatient Rehabilitation admissions and skilled nursing facility admissions** are payable up to a combined maximum of **60 days per person per Calendar Year**. • **Inpatient rehabilitation requires precertification**. See the Utilization Review and Case Management Article for details. • **Outpatient physical therapy and speech therapy** are payable to a maximum of **40 visits per person per Calendar Year**. ◦ **Habilitation services** include speech therapy for developmentally delayed individuals payable to a maximum of **20 visits per person per Calendar Year**. This **Speech therapy requires precertification.** See the Utilization Review and Case Management Article for details. • **Outpatient occupational therapy** is payable to a maximum of **40 visits per person per Calendar Year**. • Maintenance Rehabilitation, coma stimulation services are not covered. See specific Exclusions relating to Rehabilitation in the Medical PPO Plan Exclusions Article and the Definition of Maintenance Rehabilitation in the Definitions Article.	**Outpatient Visits:** After Deductible met you pay a $50 Copay per therapy modality. **Inpatient Rehabilitation:** After the deductible is met there is an additional **$300 copay for the first day, then $150 copay per day following** , up to the $1,500 coinsurance/copay limit per admission.	**Outpatient Visits and Home Visits:** After Deductible met the Plan pays 50% of allowable expenses. **Inpatient Rehabilitation:** Not covered.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). Subacute Facility/Long Term Acute Care (LTAC).	• Services must be ordered by a Physician. • **Skilled Nursing Facility or Subacute Facility requires precertification**. See the Utilization Review and Case Management Article for details. • **Skilled nursing facility and Inpatient Rehabilitation admissions are payable** up to a combined maximum of **60 days per person per Calendar Year**.	After the deductible is met there is an additional **$300 copay for the first day, then $150 copay per day following** up to $1,500 per admission; then the Plan pays 100% of coinsurance.	Not covered.
Spinal Manipulation Services • Spinal Manipulation Services (from a Physician or Chiropractor) including related ancillary services (e.g., office visit, x-rays, physical therapy, diagnostic tests in addition to spinal manipulation.	• Annual Maximum Plan Benefit for all Spinal Manipulation services is **15 visits** per person per Calendar Year.	After Deductible met you pay a $65 Copay per visit or therapy modality.	After Deductible met the Plan pays 50% of allowable expenses.
Transplants (Organ and Tissue) • Coverage is provided only for eligible services directly related to Medically Necessary and non-experimental transplants of human organs or tissue including bone marrow, peripheral stem cells, cornea, heart, heart/lung, intestine, islet tissue, kidney, kidney/pancreas, liver, liver/kidney, lung(s), pancreas, bone, tendons or skin, along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies.	• **Transplant services including pre-transplant workup tests require precertification**. Non-network facility/provider will only be authorized in an emergency situation where patient transport to an in-network provider is not safe. See the Utilization Review and Case Management Article for details. • See the specific Exclusions related to Experimental and Investigational Services and Transplants in the Medical PPO Plan Exclusions Article. • For plan Participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan.	See the Hospital row and Physician services row for payment information.	After Deductible met the Plan pays 50% of allowable expenses.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

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Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Wellness (Preventive Program Well Child Examinations and Immunizations The wellness/preventive services payable by this Plan are designed to be consistent with Health Reform regulations as outlined to the right. • Preventive services are payable without regard to gender assigned at birth, or current gender status. • The Plan pays for outpatient newborn and well Child visits and routine Childhood immunizations that are FDA approved and in accordance with the CDC recommendations for Children in the US., including immunizations such as DPT, Polio, MMR, HIB, hepatitis, chicken pox, tetanus, influenza (flu) vaccine, HPV (e.g. Gardasil, Cervarix), etc. • Other immunizations for Children at high risk are covered under the regular medical Plan Benefits. • **Immunizations/Vaccinations Available from the Retail Pharmacy**: The Plan covers immunizations recommended by both Health Reform regulations and in accordance with the Centers for Disease Control (CDC). There is no cost-sharing when these are obtained from an in-network retail pharmacy or during an in-network physician office visit. • For children age 6 years and older with obesity, Plan covers Physician prescribed **intensive behavioral counseling** interventions to promote improvement in weight status at the visit frequency recommended by the child's Network pediatrician. • When performed in primary practices, **topical fluoride** varnish to the primary teeth of children is payable through age 5 years.	As a Retiree-only plan, this plan is not required to comply with preventive services mandates related to Health Reform. However, the wellness/preventive services payable by this Plan are designed to be consistent with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures and the Centers for Disease Control and Prevention (CDC). This website lists the types of payable preventive services, including immunizations: https://www.healthcare.gov/what-are-my-preventive-care-Benefitswith more details at http://www.uspreventiveservicestaskforce.org/BrowseRec/Index, and http://www.cdc.gov/vaccines/schedules/index.html?s_cid=cs_001 and http://www.hrsa.gov/womensguidelines/ • In addition to the wellness services listed on the website above, the Plan will pay for these wellness services: well Child office visits, well woman office visits, contraceptives, and certain over the counter drugs (payable under Drugs in this Schedule). • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. Coinsurance and Deductible) for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. Coinsurance and Deductible) will apply to the diagnostic or therapeutic services provided. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual Deductible/Copay/Coinsurance. • Services not covered under the wellness/preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions. • If a Health Reform preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. • If there is no network a provider who can provide the wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing. • See page 28 for information on plan payment for certain drugs consistent with Health Reform.	No charge.	After Deductible met, the Plan pays 50% of allowable expenses.

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the "Allowable Expense", as defined in the Definitions Article, and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network*
Wellness (Preventive) Program: Adult Health Maintenance Examinations (Age 18 & up) The wellness/preventive services payable by this Plan are designed to be consistent with Health Reform regulations as outlined to the right. Certain prescription and non-prescription drugs, consistent with Health Reform regulations, are available through the Outpatient Prescription Drug program. Preventive services are payable without regard to gender assigned at birth, or current gender status. **Health care billed as wellness** is payable as a preventive benefit. The Plan covers: • Annual routine preventive health exam. Women are permitted to receive an annual routine gynecology (GYN) health exam in addition to the annual routine preventive health exam. • If a provider orders lab or x-rays tests in addition to and at the same time as what is covered in accordance with health reform preventive care expenses, Benefits for the non-health reform related tests will be paid at the Plan's usual payment level for non-wellness/preventive lab and radiology services. • **Adult immunizations** that are FDA approved and in accordance with the Centers for Disease Control (CDC) recommendations for adults in the US, such as annual flu shot, HPV vaccine (e.g. Gardasil, Cervarix), shingles vaccine, etc. Travel vaccine excluded. • **Immunizations/Vaccinations Available from the Retail Pharmacy**: The Plan covers immunizations recommended by both Health Reform regulations and in accordance with the Centers for Disease Control (CDC). There is no cost-sharing when these are obtained from an in-network retail pharmacy or during an in-network physician office visit. **Colon cancer screening** is payable for adults age 45 and older, including fecal occult blood test annually, stool DNA testing annually, AND screening colonoscopy every 10 years, or any of these tests once every five (5) years: virtual colonoscopy, double contract barium enema, or flexible sigmoidoscopy. No charge for the bowel prep medication prescribed for use prior to a screening colonoscopy or for the cost of polyps removed during a screening colonoscopy.	As a Retiree-only plan, this plan is not required to comply with preventive services mandates related to Health Reform. However, the wellness/preventive services payable by this Plan are designed to be consistent with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures, & the Centers for Disease Control and Prevention (CDC). These websites list the types of payable preventive services (such as immunizations, mammogram, pap smear, colonoscopy with polyp removal): https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at https://www.hrsa.gov/womensguidelines/, http://www.cdc.gov/vaccines/schedules/index.html?s_cid=cs_001 and https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/. In addition to the wellness services listed on the websites here, the Plan will pay for these wellness services: an annual wellness/physical exam for adults, well woman office visits, annual prostatic specific antigen (PSA) lab test for men age 40 and older. • Certain additional preventive care expenses are payable for all covered females (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-Benefits including but not limited to well woman office visits, screening for gestational diabetes, BRCA breast cancer gene test, HPV testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, annual HIV screening and counseling, while breastfeeding Plan covers breastfeeding equipment and supplies needed to operate pump and lactation support). When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. Preventive services are those services performed for screening purposes when the individual does not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the individual has a condition or an active symptom of a condition. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. The diagnosis & procedure codes the provider submits determine whether a service is considered preventive. • If a Health Reform preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan uses reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. • Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than "wellness," claims will be processed under the Plan's usual Deductible/Copay/Coinsurance. Services not covered under the wellness/preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles, Coinsurance or Copayments, and other Plan provisions. • If there is no network provider who can provide the wellness service, then the plan will cover the service when performed by an out-of-network provider without cost-sharing. • See page 28 for information on plan payment for certain drugs consistent with Health Reform. • As a preventive counseling benefit consistent with Health Reform, the Plan covers Physician prescribed **intensive behavioral counseling interventions** for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	No charge. .	After Deductible met, the Plan pays 50% of allowable expenses.

ARTICLE VI. MEDICAL NETWORKS FOR THE MEDICAL PPO PLAN

Section A. In-Network And Out-Of-Network Services.

1. Plan Participants may obtain health care services from In-Network or Out-of-Network Health Care Providers. But the amount that you pay for such services may vary. **Your lowest out-of-pocket costs occur when you use a network provider.**

   Because Health Care Providers are added to and deleted from networks during the year you should call the network or ask the provider to verify their contracted network status before you visit that provider to assure you will be able to receive their discounted price for the services you need. If you obtain and rely upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network.

2. **IN-NETWORK SERVICES:** In-Network Health Care Providers have agreements with the Plan's Preferred Provider Organization (PPO) under which they provide health care services and supplies for a favorable negotiated discount fee for plan Participants.

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

   (a) The In-Network Health Care Provider generally deals with the Plan directly for any additional amount due. Note that with respect to claims involving any third party payer, including auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the contract between the Health Care Providers and the PPO Network may not require them to adhere to the discounted amount the Plan pays for covered services, and the providers may charge their usual non-discounted fees.

   IMPORTANT NOTE

   Because providers are added to and dropped from the PPO network periodically throughout the year it is best if you ask your Health Care Provider IF they are still participating with the PPO or contact the network each time BEFORE you seek services. If you obtain and rely upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network.

   (b) You may also verify if your Health Care Provider is an In-Network provider by contacting the PPO at their phone number and website listed on the Quick Reference Chart in the front of this document.

3. **OUT-OF-NETWORK SERVICES:** Out-of-Network Health Care Providers (also called Non-Network, non-PPO and Non-participating providers) have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the Plan Participant for the Allowable Expense (as defined in this document) for any Medically Necessary services or supplies, subject to the Plan's Deductibles, Coinsurance (on non-discounted services), Copayments limitations and Exclusions.

   (a) Plan Participants must submit proof of claim before any such reimbursement will be made.

   (b) **CAUTION: Out-of-Network Health Care Providers may bill you for any balance that may be due in addition to the Allowable Expense amount payable by the Plan, also called balance billing. The amount of the Allowable Expense is generally much less than the billed charges. You can avoid balance billing by using In-Network providers.** (See the Definitions of Allowable Expense and Balance Billing in the Definitions Article of this document. Refer also to the Special Reimbursement Provisions discussed later in this Article.)

   REMINDER:
   Cancer Treatment Centers of America is not covered by this Plan. You must obtain authorization for services from Mayo Clinic or the City of Hope by contacting both the Clinical Director (at the Administrative Office) and the Utilization Management Company.

4. **Preferred Provider Organization (PPO).**

(a) The Plan's Preferred Provider Organization (PPO) is a network of Hospitals, Physicians, laboratories and other Health Care Providers who are located within a Service Area and who have agreed to provide health care services and supplies for favorable negotiated discount fees applicable only to Plan Participants.

(b) If you receive Medically Necessary services or supplies from a PPO Provider you will pay a smaller Deductible than if you received those Medically Necessary services or supplies from a Health Care Provider who is not a PPO Provider; **and** the PPO Provider has agreed to accept the Plan's payment plus any applicable Coinsurance or Copayment that you are responsible for paying as payment in full.

5. **Directories of Network Providers.**

(a) Physicians and Health Care Providers who participate in the Plan's Network are added and deleted during the year. At any time, you can find out if any Health Care Provider is a member of the Network by contacting the Medical PPO network at their website (to access their free provider network directory) shown on the Quick Reference Chart in the front of this document. The Administrative Office can also help you locate a network provider.

(b) **Remember,** because providers are added to and dropped from the PPO network periodically throughout the year **it is best if you ask your Health Care Provider IF they are still participating with the PPO or contact the network each time BEFORE you seek services.** If you obtain and rely upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network.

Section B. Special Reimbursement Provisions.

1. The following chart explains the Plan's special reimbursement for services when certain Out-of-Network providers are used. The Board of Trustees or its designee determines if and when the following special reimbursement circumstances apply to a claim.

2. Medical records may be requested in order to assist with a determination on the need for special reimbursement provisions. Allowable Expense is defined in the Definitions Article of this document.

The chart below outlines the Plan's Special Reimbursement provisions:

SPECIAL REIMBURSEMENT PROVISIONS This chart explains the Plan's special reimbursement provisions if the services of certain Out-of-Network Providers are used. The Board of Trustees or its designee determines if/when the following reimbursement applies to a claim. Without authorization there is no guarantee the claim can be considered for payment.	**WHAT THE PLAN PAYS** (toward eligible claims submitted by an Out-of-Network provider)
(a) The non-grandfathered medical plan does not have an in-network provider qualified or available to provide covered preventive services so the Participant must use the services of a non-network provider and claims will be reimbursed without any Participant cost-sharing, in the same manner as if an in-network provider had been used. (b) Child over 19 resides temporarily outside the service area while attending college. (c) If you obtain and rely upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network. (d) The individual was treated by an Out-of-Network facility/professional because of the lack of availability of an In-Network facility/professional.	As if the care was provided In-Network including Deductible, Coinsurance, Copays and Out-of-Pocket Limit and the allowance for bills will be reimbursed according to the Allowable Expense for Non-Network providers. See the Definition of Allowable Expense in the Definitions Article of this Plan.
(e) Use of an Out-of-Network provider when an In-Network provider was available to be used.	As if the care was provided Out-of-Network including Deductible, Coinsurance, Copays and Out-of-Pocket Limit.

ARTICLE VII. UTILIZATION REVIEW AND CASE MANAGEMENT (UR/CM)

Section A. Purpose of the Utilization Review and Case Management (UR/CM) Program.

1. Your plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. The development of new drugs, medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for the Fund to afford the cost of maintaining your plan. To enable your plan to provide coverage in a cost-effective way, your plan has adopted a Utilization Review and Case Management Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Fund is better able to afford to maintain the Plan and all its Benefits.

2. If you follow the procedures of the Plan's Utilization Review and Case Management Program, you may avoid some Out-of-Pocket costs. However, if you don't follow these procedures, your plan provides reduced Benefits, and you'll be responsible for paying more out of your own pocket.

Section B. Management of the Utilization Review and Case Management Program.

1. The Plan's Utilization Review and Case Management Program is administered by various independent professional review firms (including the Utilization Review and Case Management Company, Behavioral Health Program, Prescription Drug Program and Administrative Office) operating under a contract with the Plan. The name, address and telephone number of the UR Company, Prescription Drug Program and Administrative Office appears in the Quick Reference Chart in the front of this document.

2. The health care and clinical professionals in these review firms focus their review on the necessity and appropriateness of services such as hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical, surgical, drug-related or dental services. In carrying out its responsibilities under the Plan, these review firms have been given discretionary authority by the Board of Trustees to determine if a course of care or treatment is Medically Necessary with respect to the patient's condition and within the terms and provisions of this Plan.

3. **Elements of the Utilization Review and Case Management Program**: The Plan's Utilization Review and Case Management Program consists of:
   (a) **Precertification (preservice) review**: review of proposed health care services before the services are provided;
   (b) **Concurrent (continued stay) review**: ongoing assessment of the health care as it is being provided, typically involving inpatient confinement in a hospital or health care facility or review of the continued duration of healthcare services;
   (c) **Second and third opinions**: consultations and/or examinations designed to take a second, and, when required, a third look at the need for certain elective health care services;
   (d) **Retrospective (post-service) review**: review of health care services after they have been provided; and
   (e) **Case Management**: a process whereby the patient, the patient's family, Physician and/or other Health Care Providers, and the Fund work together under the guidance of the Plan's independent review firms (typically the Utilization Review and Case Management Company or Behavioral Health Program) to coordinate a quality, timely and cost-effective treatment plan. Case Management services may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices. Most case management under this Plan is voluntary (optional), however; some case management is mandatory. See the Case Management section in this Article for more details.

Section C. Restrictions and Limitations of the Utilization Review and Case Management Program (Very Important Information.

1. The fact that your Physician recommends Surgery, Hospitalization, confinement in a Health Care Facility, or that your Physician or other Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage under the Medical Plan.

2. The Utilization Review and Case Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan Benefits. The review firm's certification that a service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of Benefits are subject to the terms and conditions of the Plan as described in this document. For example, Benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.

3. All treatment decisions rest with you and your Physician (or other Health Care Provider). You should follow whatever course of treatment you and your Physician (or other Health Care Provider) believe to be the most appropriate, even if the review firm does not certify proposed surgery/treatment/service or admission as Medically Necessary or as an eligible expense. However, the Benefits payable by the Plan may be affected by the determination of the review firm.
4. With respect to the administration of this Plan, the Fund, any Fund employee, and the review firms are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the review firm as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the review firm as Medically Necessary.
5. Precertification of a service does not guarantee that the Plan will pay Benefits for that service because, other factors, such as ineligibility for coverage on the actual date of service, the information submitted during precertification varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

Section D. Precertification (Preservice) Review. (Preservice) Review.

1. **How Precertification Review Works**: Precertification Review is a procedure, administered by a review firm, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, Drug, Dental Service or other health care services are Medically Necessary.
2. **The following services must be precertified (pre-approved) by the appropriate review firm BEFORE the services are provided.** You will be notified of any changes to this precertification list of service.

WHAT SERVICES MUST BE PRECERTIFIED BY THE PRESCRIPTION DRUG PROGRAM:

Certain medications require precertification by contacting the Prescription Drug Program, whose contact information is listed on the Quick Reference Chart in the front of this document.
See the Drug row in the Schedule of Medical PPO Plan Benefits for the list of drugs needing precertification.

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

WHAT SERVICES MUST BE PRECERTIFIED BY THE DENTAL PLAN CLAIMS ADMINISTRATOR:

Certain dental services require precertification (prior authorization) by contacting the Administrative Office whose contact information is listed on the Quick Reference Chart in the front of this document.
See the Schedule of Dental PPO Plan Benefits for the services needing precertification.

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

WHAT SERVICES MUST BE PRECERTIFIED BY THE BEHAVIORAL HEALTH PROGRAM:

Elective Hospital admissions and residential treatment program admissions for mental health and substance use care require precertification by contacting the Behavioral Health Program, whose contact information is listed on the Quick Reference Chart in the front of this document.

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

WHAT SERVICES MUST BE PRECERTIFIED BY THE UTILIZATION REVIEW AND CASE MANAGEMENT COMPANY:

(a) Elective **Hospital admissions**, including admissions for medical or surgical care. (*Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section*);

(b) Elective Surgery to be performed in a Hospital-based **outpatient surgery center** or free-standing Ambulatory Surgical Facility/Center.

(c) An **upcoming transplant** as soon as the Participant is identified as a potential transplant candidate;

(d) Elective admissions to a **Skilled Nursing Facility or Subacute facility**.

(e) Admissions to any type of Health Care Facility for **Inpatient Rehabilitation**.

(f) Planned use of a **hospital or outpatient surgery facility for a Dental purpose**.

(g) **Speech therapy**.

(h) **Home Health Care**, Home Infusion Services and Enteral Therapy Services.

(i) **These diagnostic tests** (MRI, CT scans, PET scans, CT angiography, MRA, diagnostic tests billed over $500, and RAST and MAST allergy blood testing.

(j) **Durable Medical Equipment over $500 per item**.

(k) **Non-emergency medical transportation** services.

(l) **Implantable hearing devices**, such as a cochlear implant.

(m) **Nondurable medical supplies needed for more than a 6-month period**.

(n) Hyperbaric oxygen treatment

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

(p) For individuals who will participate in a **clinical trial**, precertification is required in order to notify the Plan that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.

(q) Administration of a **class of drugs called "survival motor neuron-2 (SMN2)-directed antisense oligonucleotides,"** which includes drugs such as Spinraza (nusinersen).

(r) Any technique that uses genes to treat or prevent disease (**gene therapy**) including but not limited to Kymriah, Yescarta, Luxturna, etc.

Prior notification does not mean Benefits are payable in all cases.
Coverage depends on the services that are actually provided, your eligibility status at the time service is provided, and any benefit limitations.
There is no requirement to precertify the use of a hospital-based emergency room visit.
Precertification and/or preauthorization requirement is waived for Mayo Clinic when receiving care through the Mayo Clinic Complex Care Program.

3. **How to Request Precertification (Pre-service Review).**

(a) **It is your responsibility to assure that precertification occurs when it is required by this Plan. Any penalty for failure to precertify is on you, not the Health Care Provider**.

(b) You or your Physician must call the appropriate review firm at their telephone number shown in the Quick Reference Chart in the front of this document.

(c) **Calls for elective services should be made at least 7 days before the expected date of service.**

(d) The caller should be prepared to provide all of the following information: the Fund's name, Retiree's name, patient's name, address, and phone number and social security number; Physician's name, and phone number or address; the name of any Hospital or outpatient facility or any other Health Care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.

(e) When calling to precertify, if the preservice review process was not properly followed the caller will be notified as soon as possible but not later than 5 calendar days after your request.

(f) If additional information is needed, the review firm will advise the caller. The review firm will review the information provided, and will let you, your Physician and the Hospital or other Health Care Provider, and the Claims Administrator know whether or not the proposed health care services have been certified as Medically Necessary. The review firm will usually respond to your treating Physician or other Health Care Provider **by telephone within 3 working days (but not later than 15 calendar days) after it receives the request and any required medical records and/or information**, and its determination will then be confirmed in writing.

(g) If your admission or service is determined not to be Medically Necessary, you and your Physician will be given recommendations for alternative treatment. You may also pursue an appeal. See the Claim Filing and Appeal Information Article regarding appealing a UR determination.

Section E. Concurrent (Continued Stay) Review.

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

Section F. Emergency Hospitalization.

1. If an emergency requires hospitalization, there may be no time to contact the UR Company or Behavioral Health Program before you are admitted. If this happens, the UR Company or Behavioral Health Program must be notified of the hospital admission within 48 hours. You, your Physician, the hospital, a family member or friend can make that phone call to the UR Company or Behavioral Health Program. This will enable the UR Company or Behavioral Health Program to assist you with your discharge plans, determine the need for continued medical services, and/or advise your Physician or other Health Care Providers of the various In-Network support providers and Benefits available for you and offer recommendations, options and alternatives for your continued medical care.

Section G. Pregnancies.

1. Pregnant women should notify the UR Company as soon as possible once they know they are pregnant. This helps to assure that the pregnant woman will receive adequate prenatal care, allow for planning for the upcoming delivery, and enable the Plan to provide adequate educational material regarding pregnancy. It also enables the UR Company to work with the treating Physician to monitor for high risk pregnancy factors and to assist the pregnant woman in completing the steps to assure that Plan Benefits will be available for the newborn Child.

Section H. Retrospective (Post-Service) Review.

1. All claims for medical services or supplies that have not been reviewed under the Plan's Precertification, Concurrent (Continued Stay) Review may, at the option of the Claims Administrator, be subject to retrospective review to determine if they are Medically Necessary. If the Claims Administrator receives a determination from a review firm that services or supplies were not Medically Necessary, **no Benefits will be provided by the Plan for those services or supplies.**
2. A Registered Nurse (RN) Clinical Director performs a variety of retrospective claim reviews to assist the Administrative Office staff in determining whether certain claims are payable by the Plan. See also the section of this Article regarding Appealing a Utilization Review and Case Management Determination. For complete information on claim review and claim appeals, see the Claim Filing and Appeals Information Article of this document.

Section I. Case Management Including Mandatory Case Management.

1. Diagnosis, care and treatment plans may be reviewed to determine whether effective, efficient care is being provided or accessed. **Case management means** medical or other healthcare management services to assist patients, their healthcare providers, and the Plan, and facilitate proper, effective and efficient care, including identifying and facilitating additional medical resources and treatments, expanding and providing information about treatment options, and facilitating activities and communications among professionals.

2. For example, a patient's needs may be met as well or better by offering an alternative to an acute care hospital confinement. Such alternatives could include home, Hospice, or Skilled Nursing Facility care. In cases involving long-term disabling diseases or frequent readmissions, the Plan's case management organization may assist the patient's Physician to assess whether additional alternative care is appropriate or warranted for the patient. In some cases, determined in the sole discretion of the Trustees, case management may be optional. However, in other cases, also determined in the sole discretion of the Trustees, **case management may be mandatory (such as with home health care services)**.

3. The Trustees have the full authority and discretion to require or mandate case management.

   (a) Circumstances for case management include, but are not limited to, chronic illnesses, acute catastrophic injury, infectious diseases, burns, terminal illness, transplants, major surgery, prescription drugs (for example narcotics or other controlled substances), high risk pregnancies, neonatal complications, AIDS and AIDS related cases, among others.

   (b) Case management also can include required independent medical examinations and evaluations, referrals and participation in Employee Assistance Programs (EAP) and specialty providers, among others.

   (c) The Registered Nurse (RN) Clinical Director at the Fund Office assists in case management activity.

   (d) **Failure to Comply with Mandatory Case Management**: If the covered person for whom case management is mandated, and/or his or her treating health care providers, including Physicians, fail or refuse to fully and faithfully cooperate with and participate in case management when mandated, as determined in the sole discretion of the Trustees, **all Plan Benefits, including medical, prescription drug, dental and vision Benefits, for the Participant are reduced by seventy-five percent (75%).**

   (e) If there are repeated failures or refusals to fully and faithfully participate in or fully cooperate and comply with mandatory case management, or if determined in the sole discretion of the Trustees, all coverage under the Plan is suspended and no Benefits shall be payable to that person.

   (f) In mandatory case management cases involving narcotics and a Plan determination that the Participant and/or his treating health care providers have failed or refused to fully and faithfully participate in, or fully cooperate and comply with mandatory case management, coverage under the plan for narcotics is entirely excluded.

Section J. Appealing A UR Determination (Appeals Process).

1. You may request an appeal of any adverse review decision made during the precertification, concurrent review, retrospective review, Case Management described in this Article. To appeal a denied claim/bill, see the Claim Filing and Appeal Information Article of this document.

Section K. Failure To Follow Required Utilization Review And Case Management Procedures (Very Important Information).

1. If you don't follow the Precertification Review, Concurrent (Continued Stay) Review, or Case Management procedures, or if you undergo a medical procedure that has not been determined to be Medically Necessary under the Second or Third Opinion Program, the Claims Administrator will request that the review firm perform a retrospective review to determine if the services performed or received were Medically Necessary.

2. If the review firm determines that the services were **not Medically Necessary, no Plan Benefits will be payable for those services.**

For failure to precertify the services required by the Plan, which are later determined to NOT have been medically necessary, no Plan benefits are payable.

3. If the review firm determines that the services **were Medically Necessary**, Benefits payable by the Plan (for all services received that were subject to the Utilization Review and Case Management review procedures and requirements set forth in this Article that you did not follow) will be determined by using the eligible Allowable Expenses.

For failure to follow the mandatory case management if required by the Plan, medical and prescription drug Plan Benefits are reduced by 75%.

4. Note that the failure to precertify penalty does not apply to failure to timely notify the UR Company or Behavioral Health Program of an emergency admission or an admission for delivery of a baby.

5. **The difference between the amount you would be responsible for paying based on the Benefits that would be payable if the review procedure had been followed and the actual Benefits payable because the review**

procedure/mandatory case management was not followed <u>will not count toward (accumulate to meet) the Plan's Deductible or Out-of-Pocket Limit</u>. See also the Claim Filing and Appeals Information Article of this document.

Section L. Alternative/Substitute Treatment Plan (AST Plan).

1. The Plan specifies certain types, levels and limitations of Benefits and services. In addition to those specified in the Plan, the Board of Trustees may elect to provide Benefits or services pursuant to a Board approved Alternative/Substitute Treatment Plan ("AST Plan") for an eligible person.
2. The Board will only authorize an AST Plan when the Board, in its sole and absolute discretion based on such medical and other information and advice the Board deems sufficient and appropriate, determines that such an AST Plan is Medically Necessary and appropriate and that such AST Plan is both cost effective and less costly to the Plan than treatment otherwise available under the Plan rules.
3. If the Board elects to approve an AST Plan, it will do so only for as long as such services are Medically Necessary, appropriate and cost effective for the Plan, and the total Benefits paid for such services do not exceed the total Benefits to which the claimant would otherwise be entitled under this plan in the absence of an AST plan.
4. Any election by the Trustees to use an AST Plan shall not be construed as a waiver of the right of the Board to administer the Plan in strict accordance with the provisions of the Plan document and the Plan rules and regulations.
5. This provision for an AST Plan is not a means of plan redesign, nor is it intended to be applied to authorize procedures that are not FDA approved or otherwise Experimental. It is not intended to be applied to Experimental, non-FDA approved or over-the-counter drugs or medications.

ARTICLE VIII. MEDICAL PPO PLAN EXCLUSIONS

The following is a list of services and supplies or expenses **not covered (excluded) by the Medical PPO Plan**. The Board of Trustees, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Medical program has been delegated, will have discretionary authority to determine the applicability of these Exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. General Exclusions are listed first followed by specific medically related plan exclusion.

Section A. General Exclusions (applicable to all Medical PPO Plan services and supplies including outpatient prescription drug coverage under the Medical PPO Plan).

1. **Autopsy:** Expenses for an autopsy, forensic examination and any related expenses, except as required by the Board of Trustees or its designee.
2. **Costs of Reports, Bills, etc.:** Expenses for preparing forms, medical/dental reports/records, bills, disability/sick leave/claim forms and the like; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, e-mailing charges, prescription refill charges, disabled person license plates/automotive forms, interest charges, late fees, mileage costs, provider administration fees, concierge/retainer agreement/membership/surcharge fees or provider's special plan charging fees to access added Benefits and/or photocopying fees.
3. **Educational Services:** Even if they are required because of an injury, illness or disability of a Covered Individual, the following expenses are not payable by the Plan: hospital charges to the extent they are allocable to scholastic education or vocational training, educational services, supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, auditory or speech aids/synthesizers, auxiliary aids such as communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.
4. **Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by the Fund, or if Benefits are otherwise provided under this Plan or any other plan that the Fund contributes to or otherwise sponsors, such as HMOs.
5. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan Benefit limitation or Maximum Plan Benefit as described in the Medical PPO Plan Benefits Article and Schedule of Medical PPO Plan Benefits section of this document.
6. **Expenses Exceeding Allowable Expenses:** Any portion of the expenses for covered medical services or supplies that are determined by the Board of Trustees or its designee to exceed the Allowable Expense as defined in the Definitions Article of this document.
7. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay are not covered. Expenses (past, present or future) for which another party is required to pay (e.g. no fault, personal injury protection, etc.) are not covered. See the provisions relating to Third Party Recovery Rules in the Coordination of Benefits Article in this document for an explanation of the circumstances under which the Plan will advance the payment of Benefits until it is determined that the third party is required to pay for those services or supplies.
8. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the medical program; or after the date the patient's coverage ends, except under those conditions described in the COBRA Article of this document.
9. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Board of Trustees or its designee to be Experimental and/or Investigational or Unproven as defined in the Definitions Article of this document.
10. **Military service related injury/illness**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, Benefits are not payable by the Plan.
11. **Illegal Act:** Services, supplies or expenses incurred in the treatment of any condition, injury or disability that in the opinion of the Board of Trustees or its designee, has arisen from participation in, or commission or attempted commission of, aggravated assault, battery or felony, or illegal activities or criminal act. This provision does not apply if the condition, injury or disability results from being the victim of domestic violence, or if the commission of the illegal act was a direct result of an underlying health factor or if it is shown that the individual was not the aggressor, initiator or party at fault.

12. **Medically Unnecessary Services:** Services or supplies determined by the Board of Trustees or its designee not to be Medically Necessary as defined in the Definitions Article of this document, except for certain wellness Benefits as outlined in the Schedule of Medical PPO Plan Benefits.

13. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Individual, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.

14. **No-Cost Services:** Expenses for services rendered or supplies provided for which a Covered Individual is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.

15. **Services Not Prescribed by a Physician**: Expenses for services/supplies that are not recommended or prescribed by a Physician, except for those covered services provided by a Health Care Practitioner as these terms are defined in this document.

16. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Covered Individual or family member of a Covered Individual or travel expenses related to a transplant, unless those expenses have been pre-approved by the UR Company. Note – this exclusion does not apply to travel expenses and lodging expenses up to allowable limits as provided by law when participants use the Mayo Clinic Complex Care Program benefit.

17. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This incorporates any injury or illness arising out of, or in the course of, any employment for wage, gain or profit, which includes but is not limited to the Occupational Disease Act for heart, lung and cancer (Nevada Revised Statutes 617.457, 617.455, 617.453). The exclusion continues to apply until and unless all administrative remedies are exhausted and it is determined by the Trustees that such workers compensation or similar law does not apply.

18. **Personal Comfort Items:** Expenses for patient convenience, including, but not limited to, care of family members while the Covered Individual is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, DVD/Compact disc (CD) and other similar devices, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, or private room (only as Medically Necessary), etc.

19. **Physical Examinations, Tests, Immunizations for Employment, School, etc.:** Expenses for physical examinations, screenings, testing and immunizations such as required for functional capacity/job analysis examinations and testing required for employment/career, commercial driving, government or regulatory purposes, insurance, school, camp, recreation, sports, vocation, workers' compensation, retirement/disability status or pension, required by any third party, education, travel, marriage, adoption, legal/judicial or administrative proceedings/orders, medical research or to obtain or maintain a license of any type.

20. **Private Room in a Hospital or Health Care Facility:** The use of a private room in a Hospital or other Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as Medically Necessary by the Board of Trustees or its designee.

21. **Medical Students or Interns:** Expenses for the services of a medical student or intern.

22. **Stand-By Physicians or Health Care Practitioners:** Expenses for any Physician or other Health Care Provider who did not directly provide or supervise medical services to the patient, even if the Physician or Health Care Practitioner was available to do so on a stand-by basis.

23. **Services Provided Outside the United States:** Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined in the Definitions Article of this document.

24. **Failure to Comply with Medically Appropriate Treatment:** Expenses incurred by any Covered Individual as a result of failure to comply with medically appropriate treatment, as determined by the Board of Trustees or its designee.

25. **Leaving a Hospital Contrary to Medical Advice:** Hospital or other Health Care Facility expenses if you leave the facility against the medical advice of the attending Physician within 72 hours after admission.

26. **Travel Contrary to Medical Advice:** Expenses incurred by any Covered Individual during travel if a Physician or other Health Care Provider has specifically advised against such travel because of the health condition of the Covered Individual.

27. **Telephone Calls:** Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, review firm, or any representative of the Plan for certain purposes, including, without

limitation: communication with any representative of the Plan or its review firm for any purpose related to the care or treatment of a Covered Individual, consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; providing advice to a new or established patient, not including advice provided as part of a therapy session; initiating therapy or a plan of care that can be handled by telephone.

28. **Internet/Virtual Office/Telemedicine Services:** Expenses related to a non-network/non-contracted online internet consultation with a Non-Network Physician or other Health Care Practitioner, also called a virtual office visit/consultation, web visit, Physician-patient web service or Physician-patient e-mail service, telemedicine (real time or store and forward types), telehealth, e-health, e-visit, remote diagnosis and treatment, real-time video-conferencing including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider. See the Quick Reference Chart for information on the covered network online visit service.
29. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.
30. **Expenses related to complications of a non-covered service**.
31. Expenses for **boarding school, foster home/care and group home**, except residential treatment program and half-way house is covered under the Behavioral Health Benefits of this Plan.
32. Expenses for **biofeedback** (a technique to teach a person to use signals from their body to reduce tension/anxiety), milieu therapy, behavioral modification, sensitivity training, hypnosis, electro-hypnosis, electro sleep therapy and electro narcosis, animal assisted therapy.
33. Expenses for educational services related to **reading and learning disorders, dyslexia, educational delays, or vocational disabilities**.
34. Expenses for **court-ordered services** (unless the services is both Medically Necessary and a covered benefit of the Plan), **parental custody services or adoption services**.
35. Expenses for and related to **Service animals**, including an animal that has been individually trained to do work or perform tasks for the benefit of an individual with a disability, such as seeing eye dogs, hearing disabled assistance dogs/birds/miniature horses and the like, seizure detection animals, diabetes/low blood sugar detection animals, service monkeys, etc. The Plan also excludes service animal supplies, transportation and veterinary expenses.
36. Expenses for **non-routine services and supplies associated with a clinical trial**, such as: (1) the investigational items, drugs, devices, or services themselves; (2) items, drugs, devices or services that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, drugs, devices or services inconsistent with widely accepted and established standards of care for a patient's particular diagnosis. For individuals who will participate in a clinical trial, **precertification is required** in order to notify the Plan that routine costs, services and supplies may be incurred by the eligible individual during their participation in the clinical trial.
37. **Untimely Filed Claims**: Expenses for services or supplies that would otherwise be covered by the Plan will not be covered or payable by the Plan if a claim for payment of such services is not submitted to the Claims Administrator within **12 months** from the date that the service is rendered or the supply provided. However, the Medical PPO network providers are required by their network contract to submit claims within **90 days** of the date of service.
38. **Charges made by a surgeon for visits** on the same day the surgeon performs a surgical procedures or during a postoperative period.
39. **Self-Inflicted Injury or Attempted Suicide:** Expenses incurred by any Covered Individual arising from an attempt at suicide or from a self-inflicted injury or illness, including complications thereof, unless the attempt arises as a result of a physical or mental health condition.
40. Injury or sickness resulting from **participation in professional sports**.
41. **Specifically Identified Providers and/or Facilities:** Regarding implementing a reasonable medical management technique with respect to the frequency, method, treatment or setting for care, all non-emergency services, supplies or other expenses for consultation, care or treatment of any injury, sickness, illness, disease or preventive services at or by **the following providers and/or facilities (notwithstanding any other provision or term or condition in the Plan) are not covered**: Cancer Treatment Centers of America is not covered by this Plan. You must obtain authorization for services from Mayo Clinic or the City of Hope by contacting both the Clinical Director (at the Administrative Office) and the Utilization Management Company.
42. **Non-human gene therapy**.

Section B. Exclusions Applicable To Specific Medical Plan Services and Supplies.

1. **Allergy/Alternative/Complementary Health Care Services Exclusions.**
   (a) Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
   (b) Expenses for prayer/faith, religious healing, or spiritual healing.
   (c) For expenses and services performed by or tests/supplies ordered or provided by a naturopathic, naprapathic and/or homeopathic provider.

2. **Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions.**
   (a) Expenses for any items that are **not** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Definitions Article of this document, including but not limited to air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, water beds, and air conditioners.
   (b) Expenses for **replacement of lost, missing, or stolen**, **duplicate or personalized** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment. See the Corrective Appliances row and Durable Medical Equipment row of the Schedule of Medical PPO Plan Benefits for information on repair, adjustment, servicing and replacement of a device under certain situations.
   (c) Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.
   (d) Expenses for **occupational therapy adaptive supplies and devices** used to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools, devices to assist in dressing and undressing, shower bench, raised toilet seat, etc.
   (e) Expenses for **nondurable supplies,** except as payable under Nondurable Supplies in the Schedule of Medical PPO Plan Benefits.
   (f) **Orthopedic or corrective shoes**.

3. **Cosmetic Services Exclusions.**
   (a) Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to removal of tattoos, breast augmentation (except reconstructive services after a mastectomy), breast reduction (including treatment of benign gynecomastia in males), elimination of redundant skin of the abdomen, surgery to improve self-esteem or treat psychological symptoms or psychosocial complaints related to one's appearance, treatment of varicose veins, upper eyelid blepharoplasty, chemical peel of the skin, cosmetic skin products such as Restylane, Renova or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Board of Trustees or its designee.
   (b) The Medical Program **does** cover Medically Necessary Reconstructive Services. To determine the extent of this coverage, see Reconstructive Services in the Schedule of Medical PPO Plan Benefits. Plan Participants should use the Plan's Precertification procedure to determine if a proposed surgery or service will be considered Cosmetic Surgery or Medically Necessary Reconstructive Services.
   (c) Laser light treatment of acne.

4. **Custodial Care Exclusions.**
   (a) Expenses for Custodial Care as defined in the Definitions Article of this document, regardless of where they are provided, including, without limitation, adult day care, Child day care, institutional care for the purpose of controlling or changing your environment, services of a homemaker, or personal care, sitter/companion service, except when Custodial Care is provided as part of a covered Hospice program.
   (b) Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are **not** considered to be provided for Custodial Care services, and are covered if they are determined by the Board of Trustees or its designee to be Medically Necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are **not covered**, even if they are Medically Necessary.
   (c) Expenses related to a nursing home (that is not a skilled nursing facility), an assisted living arrangement or a memory care/dementia care facility, adult day care, senior care facility.

5. **Dental Services Exclusions.**
   (a) Expenses for Dental services or supplies of any kind, (even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting the mouth or another part of the body) including but not limited to dental prosthetics, splints, retainers, appliances, endodontics such as root canal, dental restorations, and dental services for the care, filling, removal or replacement of teeth, or the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. Expenses for certain Dental services may be covered under

the Medical Plan if they are incurred for the repair or replacement of Accidental Injury to Teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the Plan, an accident does not include any injury caused by biting or chewing. See Oral, Craniofacial and TMJ Services in the Schedule of Medical PPO Plan Benefits to determine if those services are covered.

(b) Expenses for Orthognathic services/surgery for treatment of aesthetic malposition of the bones of the jaw such as with Prognathism, Retrognathism, Temporomandibular Joint dysfunction/syndrome or other cosmetic reasons.

(c) Expenses for dental services such as removal of teeth including wisdom teeth, gingivectomy, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement), or root canal (endodontic) therapy.

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

IMPORTANT NOTE: *you should contact the Prescription Drug Program administrator (listed on the Quick Reference Chart in the front of this document) for information about the Plan's drug formulary, the drugs that need precertification (pre-approval), drugs that have a limit to the quantity payable by this Plan, drugs that require step therapy, or for ordering of Specialty Drugs*.

(a) Pharmaceuticals requiring a prescription that have not been approved by the FDA; or are not approved by the FDA for the condition, dose, route, duration and frequency for which they are prescribed (*i.e.* are used "off-label"); or are Experimental and/or Investigational as defined in the Definitions Article of this document.

(b) Non-prescription (or non-legend or over-the-counter) drugs or medicines, except certain types of insulin, (Prilosec and Claritin which are payable as generic drugs), and certain over-the-counter (OTC) medications prescribed by a Physician or Health Care Practitioner to be covered without cost-sharing consistent with Health Reform regulations.

(c) Foods and nutritional/dietary supplements including, but not limited to, home meals, formulas, foods, special diets, food supplements, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except as provided during a covered hospitalization or as prescribed in compliance with Health Reform regulations. Nutritional support may be payable when it is determined by the Board of Trustees or its designee to be Medically Necessary, and is the sole means of adequate nutritional intake and is administered enterally (i.e., by feeding tube) or parenterally (i.e., by intravenous administration such as total parental nutrition/TPN) and is not considered a food thickener, infant formula, specialized infant formula, donor breast milk, baby food, or other non-prescription product that can be mixed in a blender. See the Enteral therapy row in the Schedule of Medical PPO Plan Benefits.

(d) Medical Foods (as defined in the Definitions Article of this document).

(e) Naturopathic, naprapathic or homeopathic products and substances.

(f) Prescriptions related to any non-covered service.

(g) Drugs, medicines or devices for:

1) non-prescription male contraceptives, such as condoms.
2) abortifacients drugs like Mifepristone.
3) fertility drug products or agents;
4) dental products such as fluoride preparations (unless required to be covered in compliance with Health Reform) and products for periodontal disease;
5) hair removal or hair growth products (*e.g.,* Propecia, Rogaine, Minoxidil, Vaniqa);
6) growth hormone and growth/height promotion drugs;
7) cosmetic products such as Retin-A and Accutane are excluded after the patient reaches age 26 unless determined to be medically necessary by the Prescription Drug Program.
8) weight management products (*e.g.,* Xenical), except those weight management prescription drugs that have a dual use for treatment of individuals with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy.
9) medical marijuana, except FDA-approved tetrahydrocannabinol (e.g. Marinol).
10) Vitamin injection, supplement or herb except as required by health reform or for treatment of a condition of vitamin deficiency diagnosed by a Physician.
11) Fish oil supplements whether available over the counter or by prescription (e.g. Lovaza).

(h) Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law. Note that some compounded prescriptions that are payable by the Plan may not be able to be obtain at mail order and instead must be obtained at a retail pharmacy location.

(i) Take-home drugs or medicines provided by a Hospital, emergency room, Ambulatory Surgical Facility/Center, or other Health Care Facility.

(j) Self-help devices such as a scale for weight or body fat measurement, pill crusher, pill splitter, magnifying glass/device, etc. except that a home personal use blood pressure measuring device is payable as Durable Medical

Equipment for pediatric/neonatal blood pressure monitoring when determined to be Medically Necessary by the Board of Trustees

(k) This Plan has adopted the prescription drug network's current formulary, including its preferred drug list, as the Plan's covered formulary. A **formulary** is a list of preferred outpatient prescription drug products, including strength and dosages, available for use by Plan participants. Based on the prescription drug network's formulary (which is updated from time to time), **certain drugs are not covered by the Plan**, and certain drugs are payable only when prior authorization is obtained through the Prescription Drug Plan. A copy of the current formulary may be obtained from the Prescription Drug Plan identified in the Quick Reference Chart at the front of this booklet.

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

8. **Fertility and Infertility Services Exclusions.**
   (a) Expenses for the treatment of infertility involving either a covered person or surrogate as a donor or recipient, including services to induce pregnancy and complications thereof; fertility prescription drugs; procedures or devices to achieve fertility; in vitro fertilization; low tubal transfer; artificial insemination; embryo transfer/transplants; gamete transfer; zygote transfer; including expenses for and related to the pregnancy, delivery fees and complications for the woman who is the surrogate; donor egg/semen or other fees; cryostorage of egg/sperm; ovarian transplant; infertility donor expenses; fetal implants; fetal reduction services; and surgical impregnation procedures.
   (b) Any services or supplies received in connection with a person acting as, or utilizing the services of a surrogate mother, or for any Child conceived for profit or pecuniary gain of any person.
   (c) Expenses related to reversal of sterilization procedures.
   (d) Expenses for and related to adoption.
   (e) Expenses for Pre-implantation Genetic Diagnosis (PGD) where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal prior to implantation for a fertility service.

9. **Foot Care/Hand Care Exclusions**
   (a) Expenses for routine foot care, (including but not limited to trimming of toenails, removal or reduction of corns and callouses, removal thick/cracked skin on heels, foot massage, hygienic/preventive care (hygienic/preventive care includes cleaning and soaking of the feet, applying skin creams to help maintain skin tone and other services that are performed when there is no evidence of a localized illness, injury or symptoms involving the foot).
   (b) Routine foot care administered by a podiatrist **is payable when Medically Necessary** for individuals with diabetes or a neurological or vascular insufficiency affecting the feet. See the Physician row of the Schedule of Medical PPO Plan Benefits for more information on payable foot treatment.
   (c) Expenses for hand care including manicure and skin conditioning and other hygienic/preventive care performed in the absence of localized illness, injury or symptoms involving the hand.

10. **Genetic Testing and Counseling Exclusions**
    (a) **Genetic Testing:** The following expenses for genetic tests are not covered, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, **except genetic tests listed as payable** in the Genetic Testing row in the Schedule of Medical PPO Plan Benefits and as required under Health Reform. Genetic services that are not covered include:
       1) **Pre-parental genetic testing (also called carrier testing)** intended to determine if an individual is at risk of passing on a particular genetic mutation, such as a family member who is unaffected but at risk for producing affected Children. No coverage for pre-parental/carrier genetic testing intended to determine if a prospective parent or parents or in vitro embryo have chromosomal abnormalities that are likely to be transmitted to a Child of that parent or parents;
       2) Expenses for **Pre-implantation Genetic Diagnosis (PGD)** where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;
    (b) No coverage of genetic testing of plan Participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the medically necessary treatment of a plan Participant.
    (c) **Home genetic testing kits/services** are not covered.
    (d) Genetic testing determined by the Plan Administrator or its designee to be **not medically necessary, experimental or investigational**.
    (e) See the Genetic Services row of the Schedule of Medical PPO Plan Benefits for a description of the genetic services that are covered by the Plan.

(f) Plan Participants should contact the Utilization Review and Case Management program for assistance in determining if a proposed Genetic Test will be covered or excluded.

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

11. **Hair Exclusions.**
    (a) Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis.

12. **Hearing Care Exclusions.**
    (a) Expenses for and related to cleaning, repair or maintenance of an external hearing aid, batteries, replacement of lost, stolen or broken hearing aids for which payment was made under this benefit; more than one external hearing aid for each ear during the timeframes noted in the Hearing row of the Schedule of Medical Benefits.

13. **Home Health Care Exclusions.**
    (a) Expenses for any Home Health Care services **other than** part-time, intermittent **skilled nursing** services and supplies. No coverage for home health aides.
    (b) Expenses under a Home Health Care program for services that are provided by someone who is not acting under the scope of his/her license and who ordinarily lives in the patient's home or is a parent, Spouse, sibling by birth or marriage, or Child of the patient; or when the patient is not under the continuing care of a Physician.
    (c) Expenses for a homemaker, custodial care, Child care, adult care or personal care attendant, except as provided under the Plan's Hospice coverage.

14. **Maternity/Family Planning/Contraceptive Exclusions.**
    (a) **Contraception:** Expenses related to non-prescription contraceptive drugs and devices for males, such as condoms.
    (b) **Termination of Pregnancy:** Expenses for elective induced abortion unless the attending Physician certifies that the health of the woman would be endangered if the fetus were carried to term or medical complications arise from an abortion.
    (c) **Home Delivery:** Expenses for pre-planned home delivery/home birth.
    (d) Expenses for **Childbirth education and Lamaze classes**. This exclusion does not apply to the extent that breastfeeding support, supplies and counseling are covered for women as discussed under the Durable Medical Equipment row and Maternity row of the Schedule of Medical PPO Plan Benefits.
    (e) Expenses related to the **maternity care and delivery expenses associated with a pregnant Dependent Child or a surrogate mother's pregnancy, delivery and complications.** This exclusion of maternity care for a pregnant Dependent Child **does not apply to the extent the expenses qualify as prenatal and postnatal care** provided under the Wellness and Preventive Services row of the Schedule of Medical PPO Plan Benefits, but the exclusion does apply to maternity services that are not office visits such as ultrasounds and delivery expenses.
    (f) Expenses related to **cryostorage of umbilical cord blood or other tissue or organs.**

For Nondurable supplies (see Corrective Appliances)

15. **Nursing Care Exclusions**
    (a) Expenses for services of private duty nurses/health care personnel.

16. **Rehabilitation Therapy Exclusions (Inpatient or Outpatient)**
    (a) Expenses for educational, job training, vocational rehabilitation, or recreational therapy.
    (b) Sports medicine treatment plans that are intended primarily to enhance athletic functions.
    (c) Expenses for massage therapy, rolfing (deep muscle manipulation and massage), craniosacral therapy (noninvasive rhythmic manipulation of the craniosacral areas) and related services.
    (d) Expenses incurred at an inpatient rehabilitation facility for any inpatient Rehabilitation Therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Board of Trustees or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including, but not limited to cognitive rehabilitation, coma stimulation programs and like services.
    (e) Expenses for Maintenance Rehabilitation (as defined under Rehabilitation in the Definitions Article of this document).

(f) Expenses for speech therapy for functional purposes including, but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering and conditions of psychoneurotic origin or for Childhood developmental speech delays and disorders which have not been surgically corrected.

(g) Expenses for Habilitation services (to help individuals attain certain functions that they never have acquired), except this Plan does cover habilitative speech therapy for developmentally delayed individuals if precertified (see Rehabilitation Services row of the Schedule of Medical PPO Plan Benefits).

17. **Sexual/Erectile Dysfunction Services Exclusions**

(a) **Treatment of Erectile Dysfunction (Impotency)**: Expenses for surgical treatment of erectile dysfunction or inadequacy, and any complications thereof. Prescription medication to treat erectile dysfunction is payable under the Prescription Drug Program when precertified.

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

(a) Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, postoperative services and drugs/medicines and all complications thereof, **except** those Transplant Services and their complications that are listed as payable under Transplantation in the Schedule of Medical PPO Plan Benefits.

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

(c) For plan Participants who serve as a donor, donor expenses are not payable unless the person who receives the donated organ/tissue is a person covered by this Plan.

19. **Vision Care Exclusions**

(a) Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK), Automated Lamellar Keratoplasty (ALK), Laser In-Situ Keratomileusis (LASIK).

(b) Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses or lenses and associated supplies, except one pair of eyeglasses is payable as a Corrective Appliance following ocular surgery to remove the lens of the eye such as with a cataract extraction, see the Corrective Appliance row of the Schedule of Medical PPO Plan Benefits. Also refer to the separate Vision PPO Plan Article.

(c) Vision therapy (orthoptics) and supplies.

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

(a) Weight loss control or management, weight loss treatment of any kind or medical or surgical treatment for weight-related disorders including but not limited to bariatric surgical interventions, treatment of complications of surgical interventions and skin reduction procedures/treatment, dietary programs, exercise programs and/or prescription drugs to promote weight control, regardless of a comorbid or underlying condition.

This exclusion does not apply to the extent that it constitutes screening and counseling for obesity or otherwise qualifies under the Wellness and Preventive Services row of the Schedule of Medical PPO Plan Benefits.

(b) Expenses for medical or surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight.

(c) Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, electronic exercise monitoring devices, work hardening and/or weight training services, or exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless, wearable sensors/trackers.

ARTICLE IX. DENTAL PPO PLAN BENEFITS

Dental Plan Benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA.
A separate election or opt out is required for dental PPO Plan Benefits.

Section A. Choice Of Dental Plans.

1. An important benefit you receive under the Plan is dental benefit coverage. The Plan offers two dental plan options to Non-Medicare Retirees. You can elect the:
   (a) **Dental PPO Plan** (described in this document) or
   (b) **Health Maintenance Organization (HMO) Dental Plan** (but only if you live in the HMO service area). The HMO Dental Plan is not described in this document. Contact the Administrative Office if you have questions about whether you reside in the service area for the HMO Dental plan and to obtain a copy of the HMO Medical Plan Benefit description.
2. When a Non-Medicare Retiree becomes eligible for coverage for the first time, the Non-Medicare Retiree must designate their choice of dental plan. The selection is made by completing an Enrollment form and submitting it to the Administrative Office.
3. Non-Medicare Retirees are eligible for the Dental PPO plan or the HMO Dental plan.

Section B. Covered Dental PPO Plan Expenses.

1. This Article outlines the self-funded Dental PPO Plan coverage. The Dental PPO Plan contracts with a network of dental providers (e.g. Dentists and dental hygienists) who extend a discount to you for covered dental services. Covered expenses are noted in the Schedule of Dental PPO Plan Benefits Article and refer to the Allowable Expense for covered services up to the maximum allowed as payable under this Dental PPO Plan.
2. You are covered for expenses you incur for most, but not all, dental services and supplies provided by a Dental Care Provider as defined in the Definitions Article of this document that are determined by the Board of Trustees or its designee to be **"Medically Necessary,"** but only to the extent that:
   (a) the Board of Trustees or its designee determines that the services are the most cost-effective ones that meet acceptable standards of professional dental practice and would produce a satisfactory result; **and**
   (b) services are not **experimental or investigational; and**
   (c) **services or supplies are not excluded** from coverage (as provided in the Dental PPO Plan Exclusions Article of this document); and
   (d) **services or supplies are not in excess** of a Maximum Plan Benefit; and
   (e) the charges for dental services are an **"Allowable Expense."** See the Definitions Article under "Allowable Expense."

Section C. Non-Eligible Dental Expenses Explained.

1. The Plan will not reimburse you for any expenses that are not Eligible Dental Expenses. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for Eligible Dental Expenses that exceed the amount determined by the Plan to be Allowable Expense.

Section D. Dental PPO Network.

1. **Network PPO Providers:** In-Network providers (licensed Dentists and dental hygienists) have a contract to provide discounted fees to you for services covered under this Dental PPO Plan. By using the services of an In-Network provider, both you and the Plan pay less.

   A current list of network dental providers is available free of charge when you contact the Dental PPO Plan whose contact information is listed on the Quick Reference Chart in the front of this document.

   To receive services, simply call a network dental provider and identify yourself as a member of this Dental PPO Plan.
2. **Non-Network (Out-of-Network, Non-PPO) Providers:** Services may be received from any licensed dental provider; however, this Plan will pay at the Non-Network benefit level as noted in the Schedule of Dental PPO Plan Benefits. The itemized bill reflecting the Non-Network provider's fees must be submitted to the Dental Plan Claims Administrator for reimbursement. You will be reimbursed according to the Allowable Expense.

Non-Network provider services may cost you more than if those same services were obtained from an In-Network provider. **Non-Network Providers may bill the Plan Participant for any balance that may be due in addition to the Allowable Expense amount payable by the Plan, also called balance billing. You can avoid balance billing by using In-Network providers.** (See the Definitions of Allowable Expense and Balance Billing in the Definitions Article of this document.)

Section E. Dental PPO Plan Deductible.

1. This Dental PPO Plan **does not have a Deductible** that must be met before the Dental Plan begins to pay Benefits.

Section F. Coinsurance.

1. The Plan pays a percentage of the Eligible Dental Expenses, and you are responsible for paying the rest. The applicable percentage paid by the Plan is shown in the Schedule of Dental PPO Plan Benefits. The part you pay is called the Coinsurance. Note that preventive dental services are paid at 100% in-network.

Section G. Maximum Orthodontia Plan Benefits.

1. The Maximum Plan Benefits payable for Orthodontia services is $1,200 per person per lifetime.

Section H. Annual Maximum Dental PPO Plan Benefits.

1. The Plan's Annual Maximum Dental Plan Benefits payable for any individual covered under this Plan is $2,000 per person per Calendar Year.

Section I. Extension Of Dental PPO Plan Coverage.

1. If dental coverage ends for any reason, the Plan will pay Plan Benefits for you or your covered Dependents until the end of the month in which the coverage ends. The Plan will also pay Benefits for a limited time (30 days) beyond that date (provided Benefits would have been paid had the coverage remained in effect), for the following:
   (a) An appliance or modification of one, or a Prosthesis (such as a full or partial Denture), if the Dentist took the impressions and prepared the abutment teeth while you were covered, **and** installs the device within 30 days after coverage ends.
   (b) A crown, bridge or gold restoration if the Dentist prepared the crown, bridge or gold restoration while you or your Dependent(s) were covered **and** installs it within 30 days after coverage ends.
   (c) Root Canal treatment, if the Dentist opened the pulp chamber of the tooth while you were covered **and** completes the treatment within 30 days after coverage ends.

Section J. Submitting Dental Claims For Benefits.

1. When you see the Dentist, you pay the Dentist for the service or make arrangements with the Dentist for payment. Once you make payment, submit the receipt to the Administrative Office with a claim form for reimbursement. If you see a participating PPO Provider, you need only pay your portion of the cost at the time of service and the PPO provider will bill the Plan directly for the rest. If your claim for a Plan Benefit is denied, you have the right to appeal the decision. The rules for appealing denied claims are described in the Claims Filing and Appeals Information Article.

Section K. When A Dental Charge Is Incurred.

1. A dental charge is incurred on:
   (a) The date the impression is taken, in the case of fixed bridges.
   (b) The date the preparation of the tooth is begun, in the case of crown work.
   (c) In the case of root canal therapy, the date the work on the tooth is begun, or the date the work is done.
   (d) The date the work is done in the case of any other work.

Section L. Prescription Drugs Needed For Dental Purpose.

1. Necessary prescription drugs needed for a dental purpose, such as antibiotics or pain medications, should be obtained using the Prescription Drug Benefit of the Medical Plan. Note that some medications for a dental purpose (such as periodontal mouthwashes are not payable by the Medical or Dental plans.

Section M. Schedule Of Dental PPO Plan Benefits.

1. A chart outlining a description of the Plan's Dental PPO Plan Benefits and the explanations of them appears on the following pages.

ARTICLE X. SCHEDULE OF DENTAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Dental PPO Plan Exclusions Article & Definitions Article of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowable Expense as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Dental Providers	*Out-of-Network Dental Providers
Annual Dental Plan Deductible		**None.** No Deductible applies to Dental PPO Plan Benefits.	
Annual Dental Plan Maximum The most this Plan will pay for all covered dental expenses for any person each Calendar Year.	• See also the Orthodontia row for information on the lifetime orthodontia Benefits.	$2,000 per person per Calendar Year.	
Diagnostic and Preventive Services • Oral examination and office visit. • Prophylaxis (cleaning of the teeth, scaling and polishing).). • Examination in connection with emergency palliative treatment or consultation purposes. • Bitewing x-rays. • Full mouth or Panorex (panoramic) x-rays. • Problem focused x-ray as required for diagnosis of a specific dental condition. • Topical application of sodium fluoride or stannous fluoride. • Space maintainers (covered for children under the age of 14). • Examination of the oral tissue. • Bacteriologic cultures, pulp vitality tests and diagnostic models (when not required for pulp).	• Preventive services are **subject to the Annual Dental Plan Maximum.** • Oral examination and Prophylaxis, scaling, cleaning and polishing payable two times per Calendar Year. Prophylaxis (cleaning) is combined with perio cleaning and scaling. • Single film x-ray • Bitewing x-rays payable up to twice per Calendar Year for individuals to age 18. Over age 18, once per Calendar Year. • Full mouth or Panorex x-rays payable once in any 24 month period. • Occlusal x-rays. • Sodium fluoride treatment payable twice per Calendar Year for individuals under the age of 19 years and Stannous fluoride treatment payable once per Calendar Year for individuals under age 18 years. • Fixed and removable space maintainers for Children under age 14.	100% of the discounted PPO provider fees	80% of the Allowable Expense amount. You may be responsible for the provider's fees that exceed the amount payable by this Plan.
Basic Services • Emergency pain treatment, unlimited, (only if no other service is performed on the same day). • Application of sealants on first and second permanent molars.	• Application of Sealants payable for Children under age 18.	80%	70% of the Allowable Expense amount. You may be responsible for the provider's fees that exceed the amount payable by this Plan.

ARTICLE X. SCHEDULE OF DENTAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Dental PPO Plan Exclusions Article & Definitions Article of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowable Expense as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Dental Providers	*Out-of-Network Dental Providers
Periodontic Services The dental plan covers the following periodontic services (bone, connective tissue and gum surrounding and supporting the teeth): • Treatment of periodontal and other diseases of the gums and mouth tissues • Gingivectomy and subgingival curettage, root planning, not to exceed once in 36 months. • Osseous surgery and grafts. • Adjunctive services: o crown splitting; o occlusal adjustment once in 60 months (except as excluded in the Dental PPO Plan Exclusions Article); o periodontal scaling and root planning covered once in 24 months • Localized delivery of chemotherapeutic agent via a controlled release vehicle into a diseased crevicular tissue, per tooth, covered once in 24 months.	• No coverage for crowns for teeth restorable by other means or for the purpose of periodontal splinting.	80% of the discounted PPO provider fees	70% of the Allowable Expense amount. You may be responsible for the provider's fees that exceed the amount payable by this Plan.
Endodontic Services The dental plan covers the following endodontic services (generally, root canals): Root canals (including necessary x-rays and cultures) Apicoectomy (root tip removal) Pulp capping.	Root canal therapy limited to a single tooth covered once per lifetime.	80% of the discounted PPO provider fees	70% of the Allowable Expense amount. You may be responsible for the provider's fees that exceed the amount payable by this Plan.
Restorative Services The dental plan covers the following types of fillings: • Amalgam, silicate cement, plastic, porcelain or composite restorations. Protective restoration filling (sometimes called sedative filling).	• Composite restorations limited to teeth numbers 5-12 and 21-28. The only composite restorations that are acceptable are those on anterior teeth; mesial occlusals on first bicuspids.	80% of the discounted PPO provider fees	70% of the Allowable Expense amount. You may be responsible for the provider's fees that exceed the amount payable by this Plan.

ARTICLE X. SCHEDULE OF DENTAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Dental PPO Plan Exclusions Article & Definitions Article of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowable Expense as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Dental Providers	*Out-of-Network Dental Providers

Prosthodontic Services
 	
The dental plan covers the following tooth replacement services:
• Crowns – acrylic, acrylic with gold, acrylic with nonprecious metal, porcelain with gold, porcelain with nonprecious metal, gold, nonprecious metal.
  • Crown buildups (pin retained) but only when teeth can be restored by crown alone.
  • Gold post and core (in addition to crown) but only for teeth that have not had root canal therapy.
  • No coverage for a gold crown or other gold restoration in excess of the amount payable for an amalgam restoration, except when required to restore a tooth to its proper contour, and there is no other reasonable means for restoring the contour of the tooth.
  • Porcelain veneered crowns or pontics placed on or in place of a tooth behind the second bicuspid are not covered to the extent the charges would be more than the charge that would have been covered for acrylic veneered crowns or pontics.
• Inlays and onlays.
• Recementing inlays and crowns and fixed bridges.
• Initial installation of partials, dentures and fixed bridges.
• Laboratory service and tissue conditioning done in connection with the covered addition to a partial or repair or relining of a denture.
• Rebases of partials, dentures and fixed bridges.
• Dental implants any related services are payable only when dentally/medically necessary due to congenital defects or disease. Dental implants require precertification by contacting the Dental Plan claims Administrator.
• Occlusal guard covered (once every 60 months) in cases of bruxism (teeth grinding or clenching) and as medically necessary.
	• Inlays and crowns are not covered if teeth can be restored with a filling material.
	• For inlays and crowns, it must be five years or more since last placement of an inlay or crown unless it can be independently determined that replacement is dentally necessary.
	• Repair of fixed bridge is payable more than one year after it was installed.
	• Adjustment of partials, dentures and fixed bridges are covered for the first 6 months of appliance.
	• Relines of partials, dentures and fixed bridges are allowed: once in 6 months.
	Rebases of partials, dentures and fixed bridges are allowed (with adequate documentation showing the necessity of the treatment) once in 2 years.
	• Repairs and replacements of partials, dentures (once in 6 months) and fixed bridges (twice in 5 years).
	• Occlusal guard repair/reline covered once in 24 months. Adjustment covered once in 12 months.
	Replacement of a prosthesis for which Benefits were paid under the dental benefit plan, is not covered if the replacement occurs within five (5) years from the date expense was incurred for the prosthesis, unless:
	a. Replacement is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth;
	b. The prosthesis is temporary and is being replaced by a permanent prosthesis; or
	c. The prosthesis, while in the oral cavity, has been damaged beyond repair as a result of injury.
		80% of the discounted PPO provider fees	60% of the Allowable Expense amount.
			
			You may be responsible for the provider's fees that exceed the amount payable by this Plan.

ARTICLE X. SCHEDULE OF DENTAL PPO PLAN BENEFITS

This chart explains the Benefits payable by the Plan. See also the Dental PPO Plan Exclusions Article & Definitions Article of this document for important information. All Benefits are subject to the Deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowable Expense as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network Dental Providers	*Out-of-Network Dental Providers
Oral Surgery The dental plan covers the following oral surgery services: Extractions: uncomplicated, surgical removal of erupted and impacted teeth and postoperative visits (sutures and complications) after multiple extractions and impaction. Other oral surgery: Incision and draining of abscess; biopsy and examination of oral tissue; removal of cyst or tumor, inflammatory lesions and bone tissue; microscopic examination once per Calendar Year; Radical resection of mandible with bone graft; Alveoplasty with ridge extension, maxillary sinusotomy for removal of tooth fragment or foreign body; Suture, soft tissue injury; Treatment of fractures and dislocation.		80% of the discounted PPO provider fees	70% of the Allowable Expense amount. You may be responsible for the provider's fees that exceed the amount payable by this Plan.
Orthodontia Services • Necessary services related to an active course of Orthodontia treatment including diagnosis, evaluation and pre-care. • The initial installation of Orthodontic appliances for an active course of Orthodontia treatment. • Adjustment of active Orthodontia appliances. • This Orthodontia benefit is for nonsurgical services provided to correct malocclusion (alignment of the teeth and or jaws) that significantly interferes with their function. • Expenses related to Orthodontia will be covered only when one or more of the conditions shown to the right have been satisfied.	• **The Maximum Plan Benefits payable for Orthodontia services is $1,200 per person per lifetime**. • Orthodontia Benefits are available for individuals under 19 years of age. • The amount of Benefits for orthodontia charges will be paid as follows: a. $300 – banding b. $300 – first six months of adjustments c. $300 second six months of adjustments d. $300 – third six months of adjustments. You are responsible for any orthodontic care that exceeds this payment schedule.	80% of the discounted PPO provider fees	80% of the Allowable Expense amount. You may be responsible for the provider's fees that exceed the amount payable by this Plan.

ARTICLE XI. DENTAL PPO PLAN EXCLUSIONS

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

Section A. General Exclusions (applicable to all dental services and supplies).

1. **Costs of Reports, Bills, etc.:** Expenses for preparing dental reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, interest charges, late fees and/or photocopying fees.
2. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan Benefit limitation, or Maximum Plan Benefit as described in the Schedule of Dental PPO Plan Benefits.
3. **Expenses** Exceeding Allowable Expenses**:** Any portion of the expenses for covered dental services or supplies that are determined by the Board of Trustees or its designee to exceed the Allowable Expense as defined in the Definitions Article of this document, or that exceed the scheduled charges for dental services.
4. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. See the provisions relating to Third Party Recovery Rules in the Coordination of Benefits Article.
5. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the dental program; or after the date the patient's coverage ends, except under those conditions described in the Extension of Dental Benefits in the Dental PPO Plan Benefits Article or under the COBRA provisions of the Plan.
6. **Experimental and/or Investigational Services:** Expenses for any dental services, supplies, or drugs or medicines that are determined by the Board of Trustees or its designee to be Experimental and/or Investigational as defined in the Definitions Article of this document.
7. **Military service related injury/illness**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, Benefits are not payable by the Plan.
8. **Illegal Act:** Expenses incurred by any Covered Individual for injuries resulting from or sustained as a result of commission, or attempted commission by the Covered Individual, of an illegal act that the Board of Trustees determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Individual, unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. The Board of Trustees' discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Covered Individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.
9. **Medically Unnecessary Services (Dentally Unnecessary):** Services or supplies determined by the Board of Trustees or its designee not to be Medically Necessary as defined in the Definitions Article of this document.
10. **Non-Dentist:** Expenses for services rendered or supplies provided that are **not recommended or prescribed by a Dentist.**
11. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This applies even if you or your covered Dependent were not covered by workers' compensation insurance, or if the Covered Individual's rights under workers' compensation or occupational disease or similar law has been waived or qualified.
12. **Services Provided Outside the United States:** Expenses for dental services or supplies rendered or provided outside the United States, except for treatment for an Emergency as defined in the Definitions Article of this document.
13. **War or Similar Event:** Expenses incurred as a result of an injury or illness due to any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.
14. **Analgesia, Sedation, Hypnosis, etc.:** Expenses for local analgesia, sedation, hypnosis and/or related services provided for apprehension or anxiety.
15. **Cosmetic Services:** Expenses for dental surgery or dental treatment for cosmetic purposes, as determined by the Board of Trustees or its designee, including but not limited to bleaching/whitening of teeth, veneers, facings enamel hypoplasia (lack

of development), and fluorosis (tooth discoloration). However, the following will be covered if they otherwise qualify as covered dental expenses and **are not covered** under your Medical PPO Plan Benefits:

(a) Reconstructive dental surgery when that service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
(b) Surgery or treatment to correct deformities caused by sickness;
(c) Surgery or treatment to correct birth defects outside the normal range of human variation;
(d) Reconstructive dental surgery because of congenital disease or anomaly of a covered Dependent Child that has resulted in a functional disorder.

16. **Drugs and Medicines**: Expenses for prescription drugs and medications that are covered under your Medical PPO Plan Benefits, and for any other dental services or supplies if Benefits as otherwise provided under the Plan's Medical PPO Plan Benefits; or under any other plan or program that the Fund contributes to or otherwise sponsors (such as HMOs); or through a medical or dental department, clinic or similar facility provided or maintained by the Fund, with the exception of expenses for prescription drugs and medications rendered through Local 14 Family Wellness Centers.
17. **Duplicate or Replacement Bridges, Dentures or Appliances:** Expenses for any duplicate or replacement of any lost, missing or stolen Bridge, Denture, Prosthesis or Orthodontic Appliance other than replacements described in the Schedule of Dental PPO Plan Benefits. No coverage for overdentures or charges for replacement of a prosthesis that can be repaired.
18. **Duplication of Dental Services:** If a person covered by this Plan transfers from the care of one Dentist to the care of another Dentist during the course of any treatment, or if more than one Dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable had but one Dentist rendered all the services during each course of treatment, nor will the Plan be liable for duplication of services.
19. **Gnathologic Recordings for Jaw Movement and Position:** Expenses for gnathologic recordings (measurement of force exerted in the closing of the jaws) as performed for jaw movement and position.
20. **Education Services and Home Use Supplies:** Expenses for dental education such as for plaque control, oral hygiene instruction, or home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick type device, fluoride, mouthwash, dental floss; dietary planning for the control of dental caries, and training in personal periodontal (plaque control, tobacco counseling CDT Code D1320); etc.
21. **Mouth Guards:** Expenses for athletic mouth guards and associated devices. Note however that an occlusal guard is payable. See Prosthodontic Services in the Schedule of Dental PPO Plan Benefits.
22. **Expenses for any dental services or appliances to increase vertical dimension**, restore occlusion, stabilize tooth structure lost by wear or bruxism (clenching/grinding of teeth) and devices for harmful habits such as thumb-sucking, except as provided as part of a payable course of Orthodontia treatment or other covered dental benefit outlined in the Schedule of Dental PPO Plan Benefits.
23. **Myofunctional Therapy:** Expenses for myofunctional therapy.
24. **Periodontal Splinting:** Expenses for periodontal splinting (tying two or more teeth together when there is bone loss to gain additional stability). No coverage for crowns for teeth restorable by other means or for the purpose of periodontal splinting.
25. **Personalized Bridges, Dentures, Retainers or Appliances:** Expenses for personalization or characterization of any Dental Prosthesis, including but not limited to any Bridge, Denture, Retainer or Appliance.
26. **Cephalometric x-rays, oral/facial photographic images and diagnostic casts**: are covered once per lifetime in conjunction with Orthodontic Services only when Orthodontia Services are a covered benefit. See Orthodontia Services as age limits may apply. However, 3D x-rays are not a covered benefit.
27. **Services Not Performed by a Dentist or Dental Hygienist:** Expenses for dental services not performed by a Dentist (except for services of a Dental Hygienist that are supervised and billed by a Dentist and are for cleaning or scaling of teeth or for fluoride treatments).
28. **Space Maintainers:** Expenses for anterior space maintainers.
29. **Treatment of Jaw or Temporomandibular Joints (TMJ):** Expenses for prevention or treatment, by any means, of jaw joint problems including temporomandibular joint (TMJ) dysfunction, disorder, or syndrome and any other craniomandibular disorders or other conditions of the joint linking the jawbone and skull, and the muscles, nerves and other tissues relating to that joint.
30. Any treatment or service for which you have **no financial liability or that would be provided at no cost** in the absence of dental coverage.
31. **Gold Restorations**, unless the tooth cannot be restored with other types of restorative materials.
32. **Precision or semi-precision attachments for prosthetic devices**. Conventional appliances are payable.
33. **Services performed on deciduous teeth near exfoliation**.
34. **Services that are an integral component of a covered treatment (e.g. unbundling)**.

35. **Fees charged for infection control procedures** and compliance with Occupational Safety and Health Administration (OSHA) requirements.
36. **Expenses related to complications of a non-covered service.**
37. Expenses for and related to **cryostorage of peripheral stem cells in teeth or other tissue.**
38. Services that are without uniform professional endorsement or are payable under any other part of the Plan;
39. A service or supply not included in the list of covered dental services in the Schedule of Dental PPO Plan Benefits;
40. Anything not furnished by a Dentist, except X-rays ordered by a Dentist, and services by a licensed dental hygienist under the Dentist's supervision; anything not necessary or dental care not customarily provided for.
41. Dental supplies or services for which Benefits are paid under the medical portion of the Plan.
42. Any portion of a charge for a service in excess of the Allowed Charge as defined in this document.
43. Services or supplies that do not meet the standards set by the American Dental Association.
44. Sedative fillings.
45. Tissue graft surgery for periodontal disease excluded, except when this criteria is met: Periodontal services, including bone replacement grafts, guided tissue regeneration, graft procedures and biological materials to aid in soft and osseous tissue regeneration are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants. Guided tissue regenerations and/or bone grafts are not benefited in conjunction with soft tissue grafts in the same surgical area.
46. Surgical Facilities.
47. An appliance, or modification of one, where an impression was made before you were covered; a crown, bridge or gold restoration for which the tooth was prepared before you were covered; root canal therapy if the pulp chamber was opened before you were covered.
48. Any appliance or restoration (other than a full denture) whose primary purpose is:
    (a) To alter vertical dimension (i.e., crown lengthening), except when determined by the Fund to be dentally necessary;
    (b) Stabilize periodontally involved teeth; or
    (c) Restore occlusion for a covered adult (except certain occlusal guards are payable as explained in the Schedule of Dental Benefits).

ARTICLE XII. VISION PPO PLAN BENEFITS

Vision PPO Plan Benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. A separate election or opt out is required for Vision PPO Plan Benefits.

Section A. Overview Of The Vision PPO Plan.

1. This Article outlines the self-funded Vision PPO Plan Benefits. The Vision PPO Plan is designed to provide for standard vision examinations and eyewear materials such as eyeglasses or contact lenses. Regular vision exams can help detect individuals who have chronic diseases that can affect the eye, such as diabetes, high blood pressure (hypertension), glaucoma, and cataracts.
2. Vision PPO Plan Benefits are administered by an independent Vision PPO Plan Claims Administrator whose name and address are listed on the Quick Reference Chart in the front of this document.

Section B. Eligibility For Vision PPO Plan Benefits.

1. The following individuals are eligible to participate in the Vision PPO Plan:
   (a) All eligible Non-Medicare Retirees and their eligible Dependents.
2. Vision Benefits are effective on the date your medical Plan Benefits are effective unless you opt out of/decline Vision PPO Plan Benefits.

Section C. Vision PPO Network.

1. The Vision PPO Plan contracts with an independent network of vision providers who extend a discount to you for covered vision services. Covered vision expenses are noted in the Schedule of Vision PPO Plan Benefits in this chapter and refer to payment for covered services up to the Allowed Charge for in-network providers or non-network providers.
2. **PPO Network Providers:** Network providers (licensed ophthalmologist, optometrist or dispensing optician) have a contract to provide discounted fees to you for services covered under this Vision PPO Plan. By using the services of an In-Network Vision PPO provider, both you and the Plan pay less (see the In-Network column of the Schedule of Vision PPO Plan Benefits).
   (a) A current list of PPO network vision providers is available free of charge when you call the Vision PPO Plan Claims Administrator whose name, address and telephone number are listed on the Quick Reference Chart in the front of this document.
   (b) **To receive services, simply call a PPO network vision provider and identify yourself as a member of this Vision PPO Plan**.
   (c) **NOTE:** <u>You must identify yourself as a member of this Vision PPO Plan at the time that you make the appointment with the In-Network PPO provider or you may not receive the In-Network discounted rates</u>.
3. **Non-Network (Non-PPO) Providers:** Services may be received from any licensed optometrist, ophthalmologist and/or dispensing optician; however, when non-network providers are used, this Plan will pay at the Non-Network benefit level as noted in the Schedule of Vision PPO Plan Benefits. The itemized paid bill reflecting the Non-Network provider's fees can be submitted to the Vision PPO Plan Claims Administrator for consideration for reimbursement. If the service is a covered benefit, you will be reimbursed according to the lesser of billed charges or the Plan's Allowed Charge (outlined in the Schedule of Vision PPO Plan Benefits).

   Non-Network provider services may cost you more than if those same services were obtained from an In-Network provider.
   (a) **Non-Network Providers may bill a Plan Participant for any balance that may be due in addition to the Allowed Charge amount payable by the Plan, also called balance billing.**
   (b) Balance billing occurs when a healthcare provider bills a patient for charges (other than Copayments, Coinsurance, or Deductibles) that exceed the plan's payment for a covered service. **<u>You can avoid balance billing by using In-Network providers</u>.** (See the Definitions of Allowed Charge and Balance Billing in the Definitions chapter of this document.)

Section D. Definition Of Terms Related to the Vision PPO Plan.

1. A **vision exam** includes a professional eye examination (vision analysis) and an eye refraction to determine the a prescription for corrective eyewear where indicated (refraction billed without an exam is not covered). The exam typically includes:
   (a) an assessment of your health history that is relevant to your vision,
   (b) external exam of the eyes for pathological abnormalities of the eyes including but not limited to the pupil, lens, eyelashes and eyelids,
   (c) internal exam including but not limited to an assessment of the lens and retina along with tonometry (measurement of the fluid pressure in the eye to help detect signs of glaucoma), visual field testing (checks peripheral visual capabilities), biomicroscopy (retina examination) and inspection of the retina with an ophthalmoscope, visual acuity (the ability to see clearly at all distances) and refraction (testing the eyes' ability to focus light rays on the retina from a distance and close-up).
2. **Contact lens exam** includes the comprehensive exam covered under the exam benefit along with the assessment of the optical and physical characteristics of the eye and the surface of the eye such as power, size, curvature, flexibility, gas-permeability, moisture/tear content, along with prescription of contact lens, fitting, evaluation, modification and dispensing of the contacts. Contact lens services may be provided by a doctor or optician. Contact lens exams are designed to ensure the proper fit of contacts and to evaluate vision with the contacts. Although the vision may be clear and a person may feel no discomfort from their lenses, there are potential risks with improper wearing or fitting of contact lenses that can affect the overall health of the eyes. The regular "vision exam" does not include a contact lens exam. A contact lens exam is in addition to a regular eye exam.
3. **Optician** means a person qualified to manufacture and dispense eyeglasses and/or contact lenses.
4. **Optometrist** is a person licensed to practice optometry. Optometrists examine the internal and external structure of the eyes to diagnose eye diseases like glaucoma, cataracts and retinal disorders; systemic diseases like hypertension and diabetes; and vision conditions like nearsightedness, farsightedness, astigmatism and presbyopia.
5. **Ophthalmologist** is a Physician (MD or DO) licensed to practice ophthalmology, including eye surgery and prescription of drugs.

Section E. Schedule of Vision PPO Plan Benefits.

Section E. SCHEDULE OF VISION PPO PLAN BENEFITS			
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision PPO Plan Exclusions in Section F.*	**In-Network PPO Provider**	**Non-Network Provider**
Vision Examination *without* contact lens fitting.	• One vision exam is payable each 12 months.	100% after you pay a $15 Copay per exam. Note that your exam Copay includes one pair of prescription eyeglasses (including frame & lenses).	After you pay a $15 Copay, the Plan pays 100%, to a maximum of $45 per exam.
Frames for Prescription Eyeglasses The Plan provides a wide selection of quality frames. Because of the cosmetic nature of frames and rapidly changing styles, this Plan has a maximum allowance on the reimbursement for frames.	• One frame is payable each 24 months.	Plan Paid Frames: 100% up to the $200 frame allowance. For other frame options not covered by the Vision Plan, the in-network provider offers you a discount. Discounts do not apply to non-network provider services.	The Plan pays 100% to a maximum of $70.

Section E. SCHEDULE OF VISION PPO PLAN BENEFITS			
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision PPO Plan Exclusions in Section F.*	**In-Network PPO Provider**	**Non-Network Provider**
Lenses for Eyeglasses	• A single vision, lined bifocal, lined trifocal or lenticular lens or lenticular lens is payable once every 12 months.	Single Vision (Standard): Plan pays 100% Lined Bifocal: Plan pays 100% Lined Trifocal: Plan pays 100% Lenticular: Plan pays 100% Standard Progressive Lenses: Plan pays 100% Anti-reflective Coating: Plan pays 100% after you pay a $30 copay For other lens options not covered by the Vision Plan, (such as premium or custom progressive lenses), the in-network provider offers you a discount. Discounts do not apply to non-network provider services.	The Plan pays 100% up to the following maximum amounts: Single Vision: up to $30. Lined Bifocal: up to $50. Lined Trifocal: up to $65. Lenticular: up to $100.
Contact Lenses The Vision Plan covers both elective contact lenses and visually necessary contact lenses. The vision plan claims administrator determines when contact lenses are visually necessary.	• Elective contact lenses (instead of eyeglasses) are payable each 12 months. • When elective contact lenses are obtained from an in-network provider, the plan will provide an allowance toward the cost of professional fees and materials as shown to the right. A 15% discount will also be applied to the in-network provider's professional fees for contact lens evaluation and fitting.	For a contact lens exam (fitting and evaluation) Plan pays 100% after you pay a $60 Copay. Elective Contact Lenses: (contacts instead of eyeglasses) Plan pays up to $120. Visually necessary professional fees and contact lens materials: Plan pays 100% For other contact lens options not covered by the Vision Plan, the in-network provider offers you a discount. Discounts do not apply to non-network provider services.	Elective contact lenses instead of eyeglasses: the Plan pays 100% up to $105. Visually necessary professional fees and contact lens materials: Plan pays up to $210.

Section E. SCHEDULE OF VISION PPO PLAN BENEFITS			
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision PPO Plan Exclusions in Section F.*	**In-Network PPO Provider**	**Non-Network Provider**
Low Vision Benefit Includes supplemental testing and supplemental aids	• Low Vision services and materials are available for people who have acuity or visual field loss that cannot be corrected with regular lenses. If a Covered Person falls within this category, the person will be entitled to professional services as well as ophthalmic materials, including but not limited to, supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, as outlined to the right. • **Maximum allowable for all Low Vision Benefits is $1,000 every two (2) years.**	Professional services for severe visual problems not corrected with regular lenses, includes: Supplemental Testing Plan pays 100% (includes evaluation, diagnosis and prescription of vision aids where indicated) Supplemental Aids: the Plan pays 75%	Supplemental Testing: the Plan pays 100% up to $125. Supplemental Aids: the Plan pays 75%.
Extra Savings and Discounts Available	• Discounts do not apply to non-network provider services, or if prohibited by the manufacturer, or to sundry items such as contact lens solutions, cases, cleaning products or repair of eyeglasses.	Retinal screening as an enhancement to a well vision exam is available at a discount from in-network providers. 20% off additional glasses and sunglasses including lens options from any Vision network PPO provider within 12 months from your last vision exam. Laser Vision Correction: Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted PPO network facilities.	Discounts not available.

Section F. Vision PPO Plan Exclusions and Limitations.

The following is a list of services and supplies or expenses **not covered (excluded) by the Vision PPO Plan**. The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Vision PPO Plan has been delegated, will have discretionary authority to determine the applicability of these Exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan.

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from the In-network Vision Provider.

1. Vision services and supplies that cost more than the Plan's allowance or are performed/received more frequently than permitted by the Plan, as noted in the Schedule of Vision PPO Plan Benefits.
2. Orthoptics (vision training to improve the visual perception and coordination of the two eyes) and supplemental testing.
3. Lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision PPO Plan Benefits.
4. Glasses secured when there is no prescription charge, such as reading glasses obtained from a drugstore.

5. Two pair of lenses or eyeglasses in lieu of bifocals.
6. Medical or surgical treatment of the eyes, including, but not limited to, refractive keratoplasty (RK) or laser assisted in situ keratoplasty (LASIK). (Note that there is a discount on laser eye surgery when performed by In-network Vision providers.)
7. Services or materials provided as a result of any Workers' Compensation Law, or similar occupational health legislation or obtained through or required by any government agency or program, whether federal, state or any subdivision thereof including safety glasses.
8. Services or supplies received for an illness that is a result of war, whether declared or undeclared.
9. Vision check-ups or screenings requested by the Participant's employer, school or government.
10. Treatment received from a medical department maintained by an employer, a mutual benefit association, a labor union, a trustee or a similar type group.
11. Experimental and/or investigational/unproven treatment or procedure.
12. Any service or material provided by any other vision care plan or group benefit plan containing Benefits for vision care.
13. Services or supplies furnished before the effective date of vision benefit coverage or beyond the termination date of vision benefit coverage.
14. Eye examinations or eyewear required as a condition of employment.
15. Expenses related to complications of a non-covered service.
16. Services performed outside of the United States of America.
17. The Vision PPO Plan is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the Vision PPO Plan will pay the cost of the allowed vision service/supply and the covered person will pay the additional cost for the extras. (Note that there is a discount on extras when obtained from In-network Vision providers.) Extras include:
    (a) oversized lenses (larger than 61mm),
    (b) optional cosmetic processes and cosmetic lenses.
    (c) coated lenses (e.g. color, mirror, scratch).
    (d) blended lenses.
    (e) laminated lenses.
    (f) polycarbonate lenses.
    (g) tinted lenses (addition of substance to produce a color) and photochromic lenses (lenses change from clear indoors to sunglass dark outdoors according to intensity of sunlight); except that Pink #1 and Pink #2 is covered.
    (h) custom progressive multi-focal lenses.
    (i) sunglasses/ultraviolet (UV) protected lenses (plain or prescription).
    (j) certain limitations on low vision care.
    (k) plano (non-prescription or less than ± .50 diopter power) lenses.
    (l) orthokeratology lenses for reshaping the cornea of the eye to improve vision.
    (m) a frame or other vision materials that cost more than the Plan allowance.

Section G. Filing A Vision Claim/Appealing A Denied Claim.

1. When you use the services of an In-Network vision provider, you should pay the provider for your appropriate Copay. The provider will typically send the remainder of their bill directly to the Vision PPO Plan for reimbursement. Note however that you will need to pay the provider for any services you purchased that are in excess of the benefit allowed under the Vision PPO Plan or are not covered by the Vision PPO Plan.
2. If you use the services of a Non-Network vision provider, you will need to pay the provider for all services and then, at a later date but within 12 months of the date of service, submit the bill (and proof of payment) to the Vision PPO Plan Claims Administrator (whose contact information is listed on the Quick Reference Chart in the front of this document).

You will be reimbursed up to the amount allowed under the Vision PPO Plan as noted in the Schedule of Vision PPO Plan Benefits.

3. Vision claims submitted beyond 12 months of the date of service may not be considered for reimbursement.

4. Reimbursement for services provided by or obtained from a Non-Network vision provider will be the **lesser** of (minus any applicable Copay) the actual amount charged or the allowed amount as determined by the Vision Plan Claims Administrator as listed in the Schedule of Vision PPO Plan Benefits under the column titled "Non-Network Provider". Your appeal of any denied vision claims should also be submitted to the Vision PPO Plan Claims Administrator. See also the Claims and Appeals Information Article for details on the post-service vision claims and appeals process.

ARTICLE XIII. CLAIM FILING AND APPEAL INFORMATION

Section A. Introduction.

1. This Article describes the procedures for filing claims for certain Benefits under this Plan and for appealing Adverse Benefit Determinations in connection with those claims in compliance with 29 CFR §2560.503-1. Claims covered by these procedures include those claims filed and appeals related to the self-funded Medical PPO Plan (including the Prescription Drug Program and Behavioral Health Program), the self-funded Dental PPO Plan, and the self-funded Vision PPO Plan benefit).
2. For claims administration and appeals under the Dental HMO plans, and the insured Life Insurance and AD&D plan, refer to the official documents of these insurance companies for details.
3. The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan Participants. The claims procedures outlined in this Article are designed to **afford you a full, fair and fast review of the claim to which it applies**. The Plan will take steps so claims and appeals are adjudicated in a manner designed to ensure the **independence and impartiality** of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits. Health care claim review experts will be selected based on their professional qualifications.
4. This Article also discusses the process the Plan undertakes on **certain appealed claims, to consult with a Health Care Professional** with appropriate training and experience when reviewing an Adverse Benefit Determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary, is experimental or investigational).

Section B. Qualified Medical Child Support Orders (QMCSO).

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

Section C. When You Must Repay Plan Benefits.

1. If it is found that the Plan Benefits paid by the Plan are too much because:
   (a) some or all of the health care expenses were not payable by you or your covered Dependent; or
   (b) you or your covered Dependent received money to pay some or all of those health care expenses from a source other than the Plan; or
   (c) you or your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the health care expenses for which Plan Benefits were paid (See also the Third Party Recovery Rules in the Coordination of Benefits Article);or
   (d) the Plan erroneously paid Benefits to which you were not entitled under the terms and provisions of the Plan; or
   (e) the Plan erroneously paid Benefits because of false information entered on your enrollment card, claim form or required documentation;

   then, the Plan will be entitled to

   1) recover overpayments from the entity to which the overpayment was made, or on whose behalf it was made; or from the participant directly;
   2) a refund from you or your Health Care Provider for the difference between the amount paid by the Plan for those expenses and the amount of Plan Benefits that should have been paid by the Plan for those expenses based on the actual facts;
   3) offset future Benefits (that would otherwise be payable on behalf of you or your Dependents) if necessary in order to recover such expenses; and/or
   4) its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

Section D. TIME LIMIT FOR INITIAL FILING OF HEALTH CARE CLAIMS

Unless otherwise specified in a network provider's contract, all claims must be submitted to the Plan within 12 months from the date of service for health claims.

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

Section E. Coordination Of Benefits (COB) Provision.

1. This Plan contains a Coordination of Benefits (COB) provision to prevent double payment for covered expenses. This provision works by coordinating the Benefits under this Plan with other similar plans under which a person is covered so that the total Benefits available will not exceed one hundred percent of allowable expenses. You may be asked to submit information about any additional coverage you have available to you so that this Plan knows whether and how much it should pay toward your eligible services. Without your cooperation in forwarding information on additional coverage to this Plan, the Plan may deny claims until the requested information is obtained. See the Coordination of Benefits Article for more information.

Section F. Additional Information Needed

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

Section G. When You Must Get Plan Approval In Advance Of Obtaining Health Care.

1. Some Plan Benefits are payable without a financial penalty only if the Plan approves payment **before** you receive the services. These Benefits are referred to as pre-service claims (also known as preauthorization or precertification). See the Definition of pre-service claims in this Article. You are not required to obtain approval in advance for emergency care including care provided in a hospital Emergency Room, or hospital admission for delivery of a baby. Services requiring precertification are explained in the Utilization Review and Case Management Article.

Section H. Key Definitions.

1. **Adverse Benefit Determination**: For the purpose of the initial and appeal claims processes, an Adverse Benefit Determination for a health care claim is defined as:
   (a) a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in this Plan or a determination that a benefit is not a covered benefit; and
   (b) a reduction in a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an item or service for which Benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate; or
   (c) a Rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.
2. **Appropriate Claims Administrator:** means the companies/organizations and types of claims outlined in the chart below. (See the Quick Reference Chart in this document for the contact information for these Appropriate Claims Administrators)

Appropriate Claims Administrator	Types of Claims Processed
Administrative Office	• Medical PPO plan post-service claims, including Behavioral Health post-service claims.
Utilization Review and Case Management Company	• Urgent, Concurrent and Pre-service claims for the Medical PPO plan
Behavioral Health/EAP Program	• Pre-service claims for EAP visits. • Urgent, concurrent and pre-service claims for behavioral health services
Prescription Drug Program	• Pre-service outpatient drugs claims • Post-service outpatient drug claims
Dental Plan Claims Administrator	• Dental PPO plan pre-service (when applicable) and post-service dental claims
Vision PPO Plan Claims Administrator	• Vision PPO plan post-service claims

3. **Claim:** For purposes of Benefits covered by these procedures, a claim is a request for a Plan Benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's authorized representative (as defined later in this Article) in accordance with the Plan's claims procedures, described in this Article.

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

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

   (a) be **written or electronically** submitted (oral communication is acceptable only for urgent care claims),
   (b) be **received by the Appropriate Claims Administrator** as that term is defined in this Article;
   (c) **name a specific individual including his/her social security number or Medicare ID number**,
   (d) **name a specific medical condition or symptom**,
   (e) **name a specific treatment, service or product** for which approval or payment is requested,
   (f) **made in accordance with the Plan's claims filing procedures** described in this Article; and
   (g) **includes all information required by the Plan and its Appropriate Claims Administrator, such as the existence of additional health coverage that would assist the Plan in coordinating Benefits**.

   A claim is NOT:

   (a) a request made by **someone other than** the individual or his/her authorized representative;
   (b) a request made by a **person who will not identify himself/herself** (anonymous);
   (c) a **casual inquiry about Benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
   (d) a request for **prior approval of Plan Benefits where prior approval is not required** by the Plan;
   (e) an **eligibility inquiry that does not request Plan Benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an Adverse Benefit Determination and the individual will be notified of the decision and allowed to file an appeal;
   (f) a **request for services and claims for a work-related injury/illness**, unless the Workers' Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim;
   (g) a **submission of a prescription** with a subsequent Adverse Benefit Determination at the point of sale at a retail pharmacy or from a mail order service.
   (h) a request for an eye exam, lenses, frames or contact lenses with a subsequent Adverse Benefit Determination at the point of sale from vision providers.

4. **Concurrent Care Claim:** A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short. The services that will receive concurrent care review are listed in the Utilization Review and Case Management Article in this document.

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

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

7. **Post-Service Claim:** A post-service claim is a claim for Benefits under the Plan that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims. A claim regarding rescission of coverage will be treated as a post-service claim.

8. **Pre-Service Claim:** A pre-service claim is a request for Benefits under this group health Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. The services that require precertification (also called prior authorization) are listed in the Utilization Review and Case Management Article and the Drug row of the Schedule of Medical PPO Plan Benefits in this document.

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

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

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

12. **Urgent Care Claim**: An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for precertification, as determined by your Health Care Professional:
    (a) could seriously jeopardize the life or health of the individual or the individual's ability to regain maximum function, or
    (b) in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, or is a claim involving urgent care.

    The services that require precertification (also called prior authorization) are listed in the Utilization Review and Case Management Article, the Schedule of Medical PPO Plan Benefits and Schedule of Dental PPO Plan Benefits in this document.

Section I. Review Of Issues That Are Not A Claim As Defined In This Article.

1. A Plan Participant may request review of an issue (that is not a claim as defined in this Article) by writing to the Board of Trustees whose contact information is listed on the Quick Reference Chart in this document. The request will be reviewed and the Participant will be advised of the decision within 60 days of the receipt of the request.

Section J. Authorized Representative.

1. This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an Adverse Benefit Determination under this Plan (because of your death, disability or other reason acceptable to the Plan). An authorized representative under this Plan also includes a Health Care Professional. Under this Plan you do not need to designate in writing that the network Health Care Professional is your authorized representative if that Health Care Professional is part of the claim appeal.

2. Under this Plan non-network providers cannot automatically be designated to be an Authorized Representative. Instead, the plan participant must make a written designation if they desire a non-network provider to be their authorized representative for a claim appeal; however, this designation does not extend to permit the non-network provider to file legal action on behalf of the participant or their claim appeal. The written Authorized Representative request should include the plan participant's name and contact information along with the authorized representative's name, address and phone number. The authorized representative request should be submitted to the Appropriate Claims Administrator.

3. The Plan requires a written statement from an individual that he/she has designated an authorized representative (except for a health care professional who does not require a written statement in order to appeal a claim for a plan Participant) along with the representative's name, address and phone number. To designate an authorized representative, you must submit a completed authorized representative form (available from the Appropriate Claims Administrator or the Administrative Office).

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

5. Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A Participant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Appropriate Claims Administrator or the Administrative Office.

6. The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

Section K. How To File A Post-Service Claim For Benefits Under This Plan.

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

2. Plan Benefits for post-service claims are considered for payment upon receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim but sometimes additional information or records may be required. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim. Generally, network Health Care Providers send their bill directly to the Plan.

3. Generally, Plan Benefits for a network provider, Hospital or Health Care Facility will be paid directly to the network provider or facility. Plan Benefits for surgery will usually be paid directly to the surgeon and anesthesiologist providing the services. For eligible claims, the Plan pays their portion of the billed services and you, the covered person, are responsible to pay your portion of the claim to the provider. When Deductibles, Coinsurance or Copayments apply, you are responsible for paying your share of these charges.

4. Often, when health care services are provided through the Preferred Provider Organizations (PPO), the Health Care Facility/Provider contracted with the PPO will usually submit the written proof of claim directly to the PPO Network for repricing or to the Appropriate Claims Administrator. This means that when using PPO network providers there are generally no forms or claims or paperwork to complete.

5. If you pay for non-PPO/non-network health care services at the time services are provided, you may later submit the bill to the Appropriate Claims Administrator. At the time you submit your claim you must furnish evidence acceptable to the Appropriate Claims Administrator that you or your covered Dependent paid some or all of those charges. When non-PPO/non-network Plan benefits will be paid to you, they will be paid up to the amount allowed by the Plan for those expenses and you may then need to reimburse the non-PP/non-network provider directly.

6. **Claim Forms:** Occasionally a health care provider will send a claim directly to you. In this case you should contact the Appropriate Claims Administrator (defined in this Article) to find out if they require you to complete a claim form. If a claim form is required it may be obtained from the Appropriate Claims Administrator whose contact information is listed on the Quick Reference Chart in this document.
   (a) Complete the Participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
   (b) The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician or Health Care Practitioner or Dentist can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:
      - A description of the services or supplies provided.
      - Details of the charges for those services or supplies, including CPT/CDT codes.
      - Diagnosis including ICD codes.
      - Date(s) the services or supplies were provided.
      - Patient's name, social security or ID number, address and date of birth.
      - Insured's name, social security or ID number, address and date of birth, if different from the patient.
      - Provider's name, address, phone number, professional degree or license, and federal tax identification number.
   (c) Please review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the Appropriate Claims Administrator.** This can reduce costs to you and the Plan.
   (d) Complete a **separate claim form** for each person for whom Plan Benefits are being requested.
   (e) If another plan is the primary payer, send a copy of the other plan's **Explanation of Benefits (EOB)** along with the claim you submit to this Plan. The EOB describes how the claim was processed, such as Allowable Expenses, amounts applied to your Deductible, if a plan maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, how to appeal a claim, etc.
   (f) Mail the claim form and a copy of the provider's actual claim to the Appropriate Claims Administrator.
   (g) If at the time you submit your claim, you furnish evidence acceptable to the Plan that you or your covered Dependent paid some or all of those charges, Plan Benefits may be able to be paid to you up to the amount allowed by the Plan for those services.

7. In all instances, when Deductibles, Coinsurance or Copayments apply, you are responsible for paying your share of the charges.

8. The Appropriate Claims Administrator will review your post-service claim no later than 30 calendar days from the date the claim is received. You will be notified if you did not properly follow the post-service claims process.

9. This 30-day period may be **extended one time for up to 15 additional calendar days** if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30 day period using a written Notice of Extension.

The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.

If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.

The Appropriate Claims Administrator will then make a claim determination no later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.

10. **Proof of Dependent Status:** (See also the Eligibility Article of this document for documents necessary for proof of Dependent Status.)
    (a) When processing claims submitted on behalf of a **Newborn Dependent Child** the Appropriate Claims Administrator must receive confirmation of the Child's eligibility for coverage (*e.g*. copy of certified birth certificate for newborn).
    (b) When processing claims submitted on behalf of a **Dependent Child who is age 26 or older,** the Appropriate Claims Administrator must receive confirmation of the Child's eligibility (e.g. Disabled Adult Child verification).
    (c) If claims are submitted on behalf of a **Dependent for whom the Plan has not yet received proof of Dependent status**, the Appropriate Claims Administrator must receive the proof of eligibility, or confirmation from the Board of Trustees of the Child's eligibility for coverage, before the claim can be considered for payment.
    (d) When processing claims submitted on behalf of a **new Spouse**, the Appropriate Claims Administrator must receive confirmation of the Spouse's eligibility (e.g. copy of marriage certificate).
11. When processing **claims related to an accident** the Appropriate Claims Administrator may need information about the details of the accident in order to consider the claim for payment.
12. The Plan will provide you, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.
13. **If the post-service claim is approved,** you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan Benefits.
14. **If the post-service claim is denied** in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable) along with the Explanation of Benefits or EOB form. This notice of initial denial will:
    (a) identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
    (b) state that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal;
    (c) give the specific reason(s) for the denial, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim;
    (d) reference the specific Plan provision(s) on which the determination is based;
    (e) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
    (f) describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
    (g) provide an explanation of the Plan's internal appeal procedure along with time limits and information regarding how to initiate an appeal;
    (h) contain a statement that you have the right to bring civil action under ERISA Section 502(a) after the appeal is completed;

(i) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
(j) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
(k) disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals.

18. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart):
(a) SPANISH (Español): Para obtener asistencia en Español, llame al 1-702-851-8286.
(b) TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-702-851-8286.
(c) CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-702-851-8286.
(d) NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-702-851-8286.

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

Section L. Appeal Of A Denial Of A Post-Service Claim.

1. This Plan maintains a 1-level appeals process. Appeals must be submitted in writing to Board of Trustees for medical plan appeals and to the Dental or Vision Claims Administrator for dental or vision plan appeals (whose contact information is listed on the Quick Reference Chart in this document). You will be provided with:
(a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for Benefits;
(b) the opportunity to submit written comments, documents, records and other information relating to the claim for Benefits;
(c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
(d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.
(e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
(f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan will:
1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
2) provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

2. Under this Plan's 1 level appeal process, the Plan will make a determination on the appeal in accordance with the timing for the Board meetings as noted below. There is **no extension permitted** in the appeal review process. Network provider appeal determinations are made by Anthem. Non-network provider appeal determinations are made by the Board of Trustees.

3. The Board of Trustees will make a medical plan Level 1 appeal determination according to the following timeframes:

(a) **If an appeal is filed with the Plan more than 30 days before the next Board meeting**, the review will occur at the next Board meeting date.

(b) **If an appeal is filed with the Plan within 30 days of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.

(c) If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

(d) After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.

For Dental or Vision plan claim appeals, the Appropriate Claims Administrator will make a determination on the Level 1 dental plan appeal no later than **60 calendar days** from receipt of the appeal. There is **no extension permitted** in the appeal review process.

4. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.

5. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit, the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

6. You will receive a notice of the appeal determination. If that determination is adverse, it will include the following:
   (a) information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   (b) the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided.;
   (c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   (d) reference the specific Plan provision(s) on which the determination is based;
   (e) a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   (f) a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   (g) an explanation of the Plan's voluntary Plan appeal procedures, if any;
   (h) if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   (i) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request;
   (j) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;" and
   (k) disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals.

7. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart):
   (a) SPANISH (Español): Para obtener asistencia en Español, llame al 1-702-851-8286.
   (b) TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-702-851-8286.
   (c) CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-702-851-8286.
   (d) NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-702-851-8286.

8. This concludes the post-service appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

Section M. How To File An Urgent Care Claim For Benefits Under This Plan.

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

2. Urgent care claims (as defined previously in this Article) may be requested by you orally or by writing to the Appropriate Claims Administrator whose contact information is listed on the Quick Reference Chart in this document.

3. In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the Definition of urgent care), the Health Care Professional will be considered by this Plan to be the authorized representative bypassing the need for completion of the Plan's written authorized representative form.

4. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

5. You will be notified of the Plan's benefit determination **as soon as possible but no later than 72 hours** after receipt of an urgent care claim by the Utilization Review and Case Management Company or Prescription Drug Program or Behavioral Health Program. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent Benefits are covered or payable under the Plan.

6. **If you fail to provide sufficient information to decide an urgent care claim**, you will be notified as soon as possible, but no later than 24 hours after receipt of the urgent care claim by the Utilization Review and Case Management Company or Prescription Drug Program or Behavioral Health Program of the specific information necessary to complete the urgent care claim and you will be allowed not less than 48 hours to provide the information. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible but no later than 48 hours after the earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.

7. **If the urgent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.

8. **If the urgent care claim is denied** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided no later than 3 calendar days after the oral notice. The notice of initial urgent care claim denial will:

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

9. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart):
   (a) SPANISH (Español): Para obtener asistencia en Español, llame al 1-702-851-8286.
   (b) TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-702-851-8286.

(c) CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-702-851-8286.

(d) NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-702-851-8286.

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

Section N. Appeal Of A Denial Of An Urgent Care Claim.

1. You may request an appeal review of an urgent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator (Utilization Review and Case Management Company, or Prescription Drug Program or Behavioral Health Program), whose contact information is listed on the Quick Reference Chart in this document.

2. You will be provided with:

(a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for Benefits;

(b) the opportunity to submit written comments, documents, records and other information relating to the claim for Benefits;

(c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity;

(e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Plan will:

1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and

2) provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

3. The Plan will make a determination on the appeal (without the opportunity for an extension) **as soon as possible but no later than 72 hours** after receipt of the appeal.

4. The notice of appeal review of an urgent care claim will be provided orally with written confirmation (or electronic, as appropriate). You will receive a notice of the appeal determination. If that determination is adverse, it will include:

(a) information that is sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);

(b) a statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. ;

(c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;

(d) reference the specific Plan provision(s) on which the determination is based;

(e) a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

(f) a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

(g) an explanation of the Plan's voluntary Plan appeal procedures, if any;

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

5. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart):
   (a) SPANISH (Español): Para obtener asistencia en Español, llame al 1-702-851-8286.
   (b) TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-702-851-8286.
   (c) CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-702-851-8286.
   (d) NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-702-851-8286.

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

Section O. How To File A Concurrent Claim For Benefits Under This Plan.

1. If your claim involves concurrent care (as that term is defined earlier in this Article), you may file the claim by writing (orally for an expedited review) to the Appropriate Claims Administrator (Utilization Review and Case Management Company or Behavioral Health Program) whose contact information is listed on the Quick Reference Chart in this document.

2. If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that Adverse Benefit Determination before the benefit is reduced or terminated.

3. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

4. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this Article.

5. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Pre-service or Post-service claim sections of this Article.

6. **If the concurrent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.

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

8. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart):
   (a) SPANISH (Español): Para obtener asistencia en Español, llame al 1-702-851-8286.
   (b) TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-702-851-8286.
   (c) CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-702-851-8286.

(d) NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-702-851-8286.

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

Section P. Appeal Of A Denial Of A Concurrent Care Claim.

1. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator (Utilization Review and Case Management Company or Behavioral Health Program), whose contact information is listed on the Quick Reference Chart in this document.
2. You will be provided with:
   (a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for Benefits;
   (b) the opportunity to submit written comments, documents, records and other information relating to the claim for Benefits;
   (c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   (d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity;
   (e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
   (f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Appropriate Claims Administrator will:
      1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
      2) provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
3. A determination will be made on the appeal (without the opportunity for extension) **as soon as possible before the benefit is reduced or treatment is terminated**.
4. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   (a) information sufficient to identify the claim involved (e.g. date of service, health care provider, claim amount if applicable);
   (b) the statement that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. ;
   (c) the specific reason(s) for the adverse appeal review decision, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim;
   (d) reference the specific Plan provision(s) on which the determination is based;
   (e) a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   (f) a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   (g) an explanation of the Plan's, along with any time limits and information regarding how to initiate the next level of review, as well as a statement of the voluntary Plan appeal procedures, if any;

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

5. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart):
   (a) SPANISH (Español): Para obtener asistencia en Español, llame al 1-702-851-8286.
   (b) TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-702-851-8286.
   (c) CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-702-851-8286.
   (d) NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-702-851-8286.
6. This concludes the concurrent claim appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

Section Q. How To File A Pre-Service Claim For Benefits Under This Plan.

1. A claim for pre-service (as defined in this Article) must be made by a claimant or the claimant's authorized representative (as described in this Article) in accordance with this Plan's claims procedures outlined in this Article.
2. A pre-service claim (claim which requires precertification) must be submitted (orally or in writing) in a timely fashion (as discussed in the Utilization Review and Case Management Article and Drug row of the Schedule of Medical PPO Plan Benefits of this document) to the Appropriate Claims Administrator (as defined in this Article).
3. The pre-service claim will be reviewed no later than **15 calendar days** from the date the pre-service claim is received by the Appropriate Claims Administrator. If you do not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.
4. The 15 calendar day review period **may be extended one time for up to 15 additional calendar days** if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 15-day period by using a written Notice of Extension.
   a) If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.
   b) The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.
   c) In either case noted above, you will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
   d) A claim determination will be made no later than 15 calendar days from the earlier of the date the additional information is received or the date displayed in the Notice of Extension on which a decision will be made if no additional information is received.
5. The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

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

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

12. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart):
   (a) SPANISH (Español): Para obtener asistencia en Español, llame al 1-702-851-8286.
   (b) TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-702-851-8286.
   (c) CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-702-851-8286.
   (d) NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-702-851-8286.

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

Section R. Appeal Of A Denial Of A Pre-Service Claim.

1. This Plan maintains a 1 level appeals process. Appeals must be submitted in writing to the Board of Trustees whose contact information listed on the Quick Reference Chart in this document. You will be provided with:
   (a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for Benefits;
   (b) the opportunity to submit written comments, documents, records and other information relating to the claim for Benefits;
   (c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   (d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

(e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Board of Trustees will:
   1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
   2) provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

2. Under this Plan's 1 level appeal process, the Plan will make a determination on the appeal no later than **30 calendar days** from receipt of the appeal. There is **no extension permitted** to the Plan in the appeal review process.

3. There is **no extension permitted** to the Plan in the first level of the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.

4. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.

5. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

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

7. If you do not understand English and have questions about a claim denial, contact the Appropriate Claims Administrator (see the Quick Reference Chart):
   (a) SPANISH (Español): Para obtener asistencia en Español, llame al 1-702-851-8286.
   (b) TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-702-851-8286.
   (c) CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-702-851-8286.
   (d) NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-702-851-8286.

8. This concludes the pre-service appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

Section S. Outline Of The Timeframes For The Claim Filing And Claim Appeal Process.

Overview of Claims and Appeals Timeframes				
	Urgent	**Concurrent**	**Pre-service**	**Post-service**
Plan must make **Initial Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days
Extension permitted during initial benefit determination?	No	No	Yes, one 15-day extension.	Yes, one 15-day extension.
Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days
Plan must make **Appeal Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	30 days	In accordance with the Board of Trustee timing in the chart below
Extension permitted during appeal review?	No	No	No	No

Post-service Appeal Timeframes for Multiemployer Plan with Committee or Boards of Trustees that meet at least Quarterly		
Appeal filed **within 30 days** of the next Board meeting:	Board review occurs no later than the second meeting following receipt of the appeal.	If special circumstances require an extension of time, Board review can occur at the third meeting following receipt of the appeal.
Appeal filed **more than 30 days** before next Board meeting:	Board review occurs at the next Board meeting date.	If special circumstances require an extension of time, Board review can occur at the second meeting following receipt of the appeal.
Board's decision on the appeal to be provided to claimant as soon as possible after the Board decision but no later than 5 days after the Board's decision date.		

Section T. Limitation On When and Where A Lawsuit May Be Started.

1. You or any other claimant may not start a lawsuit or other legal action to obtain Plan Benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional time will be necessary to reach a final decision.
2. The law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly.
3. No lawsuit may be started more than three (3) years after the end of the year in which services were provided.
4. Any claim that you may have relating to or arising under the Plan may only be brought in the United States District County for the District of Nevada. No other court is a proper venue for your claim. The U.S. District County for the District of Nevada will have personal jurisdiction over you and any other participant or beneficiary named in the action.

Section U. Discretionary Authority Of Plan Administrator And Designees.

1. In carrying out their respective responsibilities under the Plan, the Plan Administrator (the Board of Trustees) or its delegate, have full discretionary authority to interpret the terms of the Plan, to resolve ambiguities, and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

   The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder, and applying the facts to the terms of the Plan.

Section V. Elimination Of Conflict Of Interest.

1. To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions

related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of Benefits.

Section W. Facility Of Payment.

1. If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment.

   Neither the Plan, Board of Trustees, Appropriate Claims Administrator nor any other designee of the Board of Trustees will be required to see to the application of the money so paid.

ARTICLE XIV. COORDINATION OF BENEFITS (COB)

Section A. How Duplicate Coverage Occurs.

1. This Article describes the circumstances when you or your covered Dependents may be entitled to health care Benefits under the self-funded medical and dental plans (referred to in this Article as the Plan) and may also be entitled to recover all or part of your health care expenses from some other source. The COB provisions in this chapter pertain to the Medical Plan(s), Dental Plan(s) and Vision Plan(s) but the Plan does not coordinate benefits on outpatient prescription drug benefits.

   In this Article the term "you" references all covered Plan Participants. In many of those cases, either this Plan or the other source of coverage (the primary plan or program) pays Benefits or provides services first, and the other coverage (the secondary plan or program) pays some or all of the difference between the total cost of those services and payment by the primary plan or program. In other cases, only one plan pays Benefits. This can occur if you or a covered Dependent is also covered by:

   (a) Another group health care plan (including but not limited to a plan which provides the Covered Individual with COBRA Continuation Coverage); or

   (b) Medicare; or

   (c) Other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, motor vehicle insurance including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency; or

   (d) Workers' compensation.

   (e) Coverage resulting from a judgment at law or settlement.

   (f) Any responsible third party, its insurer, or any other source on behalf of that party.

   (g) Any first party insurance (e.g. medical, personal injury, no-fault, underinsured motorist or uninsured motorist coverage).

   (h) Any policy from any insurance company or guarantor of a third party

   (i) Any other source (e.g. crime victim restitution, medical, disability, school insurance).

1. The Plan's benefit coverage is excess to other responsible parties' coverage sources such as coverage from a judgment, settlement, or any responsible party.

2. Duplicate recovery of health care expenses can also occur if there is any other coverage for your health care expenses including third party liability.

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

4. In some instances, this Plan will not provide coverage if you can recover from some other resource. In other instances, this Plan will advance its Benefits, but only subject to its right to recover them if and when you or your covered Dependent actually recover some or all of your losses from a third party (see also the subrogation provisions in this Article). Duplicate recovery of health care expenses may also occur if a third party caused the injury or illness by negligent or intentionally wrongful action.

IMPORTANT INFORMATION ABOUT COORDINATION OF BENEFITS

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

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

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

Section B. Coverage Under More Than One Group Health Plan.

1. **When and How Coordination of Benefits (COB) Applies.**

   (a) For the purposes of this Coordination of Benefits Article, the word "plan" refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides Benefits payable on account of medical or dental services incurred by the Covered Individual or that provides health care services to the Covered Individual. A "group plan" provides its Benefits or services to Non-Medicare Retirees or members of a group who are eligible for and have elected coverage (including but not limited to a plan that provides the Covered Individual with COBRA Continuation Coverage).

   (b) Many families have family members covered by more than one medical or dental plan. If this is the case with your family, **you must let this Plan and the Administrative Office know about all medical and dental plan coverages when you submit a claim.**

   (c) Coordination of Benefits (or COB, as it is usually called) operates so that one of the Plans (called the primary plan) will pay its Benefits first. The other plan, (called the secondary plan) may then pay additional Benefits. **In no event will the combined Benefits of the primary and secondary plans exceed 100% of the health care expenses incurred.** Sometimes, the combined Benefits that are paid will be less than the total expenses.

Section C. Which Plan Pays First: Order Of Benefit Determination Rules.

1. **The Overriding Rules.** An individual plan is a non-group plan purchased by an individual, whether provided through a policy, subscriber contract, health care network plan, group practice or individual practice plan or through the Health Insurance Marketplace. **This Plan does not coordinate Benefits with an individual plan including a plan purchased through the Health Insurance Marketplace**.

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

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

   Rule 1: Non-Dependent or Dependent

   A. The plan that covers a person other than a Dependent, for example, as an Employee, Retiree, member or subscriber is the primary plan that pays first; and the Plan that covers the same person as a Dependent is the secondary plan that pays second.

   B. There is one exception to this rule. If the person is also a Medicare Beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (that is, the Plan covering the person as an Employee or Retiree); then the order of Benefits is reversed, so that the Plan covering the person as a Dependent pays first; and the Plan covering the person other than as a Dependent (that is, as an Employee or Retiree) pays second.

   Rule 2: Dependent Child Covered Under More Than One Plan

   A. The plan that covers the parent whose Birthday falls earlier in the Calendar Year pays first; and the Plan that covers the parent whose Birthday falls later in the Calendar Year pays second, if:
      1. the parents are married;

2. the parents are not separated (whether or not they ever have been married); or
3. a court decree awards joint custody without specifying that one parent has the responsibility for the Child's health care expenses or to provide health care coverage for the Child.

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

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

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

If the specific terms of a court decree state that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the Plan that covers the parent whose Birthday falls earlier in the Calendar Year pays first, and the Plan that covers the parent whose Birthday falls later in the Calendar Year pays second.

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

F. For a dependent child who has coverage under either or both parents' plans and also has his/her own coverage as a dependent under a Spouse's plan, the order of benefits shall be determined, as described in Rule 5 (the longer/shorter length of coverage) and if length of coverage is the same, then the birthday rule (Rule 2) applies between the dependent child's parent's coverage and the dependent spouse's coverage. For example, if a married Dependent Child on this Plan is also covered as a Dependent on the group plan of their Spouse, this Plan looks to Rule 5 first and if the two plans have the same length of coverage, then they Plan looks to whose birthday is earlier in the year: the Retiree-parent covering the Dependent or the Employee-Spouse covering the Dependent.

Rule 3: Active or Retired Employee

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

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

C. If a person is covered as a Retiree under this plan and as a Dependent of an active Employee under another plan, the order of Benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

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

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

C. If a person is covered other than as a Dependent (that is, as a Retiree, member or subscriber) under a right of continuation coverage under federal or state law under this plan and as a Dependent of an active Employee under another plan, the order of Benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

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

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

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

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

Rule 6: When No Rule Determines the Primary Plan. If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the covered individual.

Section D. How Much This Plan Pays When It Is Secondary.

1. **Secondary Liability of this Plan:** When this Plan pays second, it will pay the same Benefits that it would have paid had it paid first, **less** whatever payments were actually made by the Plan (or plans) that paid first. In no case will this Plan pay more in Benefits for each claim as it is submitted than it would have paid had it been the Plan that paid first. This has the effect of maintaining this Plan's Deductibles, Coinsurance and Exclusions. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the health care services.

2. The Plan does not administer a benefit reserve (also called a benefit bank, credit balance, credit reserve or credit savings) calculation in the coordination of Benefits.

3. **"Allowable Expense"** means a health care service or expense, including Deductibles, Coinsurance or Copayments, which is covered in full or in part by any of the Plans covering the person, except as provided below or where a statute applicable to this Plan requires a different Definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
   (a) The difference between the cost of a semi-private room in a Hospital or Health Care Facility and a private room, unless the patient's stay in a private Hospital room is determined (by the Board of Trustees it is designee) to be Medically Necessary.
   (b) If the coordinating plans determine Benefits on the basis of an Allowable Expense amount, any amount in excess of the highest Allowable Expense is not an allowable expense.
   (c) If the coordinating plans provide Benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
   (d) If one coordinating plan determines Benefits on the basis of an Allowable Expense amount and the other coordinating plan provides Benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the allowable expense for all plans.
   (e) When Benefits are reduced by a primary plan because a Covered Individual did not comply with the primary plan's provisions, such as the provisions related to Utilization Review and Case Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.
4. Allowable expenses **do not include** expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Section E. Administration Of COB.

1. To administer COB, the Plan reserves the right to:
   (a) exchange information with other plans involved in paying claims;
   (b) require that you or your Health Care Provider furnish any necessary information;
   (c) reimburse any plan that made payments this Plan should have made; or
   (d) recover any overpayment from your Hospital, Physician, Dentist, other Health Care Provider, other insurance company, you or your Dependent.

2. If this Plan should have paid Benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Board of Trustees or its designee determines to be proper under this provision. Any amounts so paid will be considered to be Benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

3. To obtain all the Benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims Benefits under this Plan must provide all the information the Plan needs to apply COB.

4. This plan follows the customary coordination of Benefits rule that the medical program coordinates with only other medical plans or programs, and not with any dental plan or program and the dental program coordinates only with other dental plans or programs and not with any other medical plan or program. Therefore, when this Plan is secondary, it will pay secondary medical Benefits only when the coordinating primary plan provides medical Benefits, and it will pay secondary dental Benefits only when the primary plan provides dental Benefits.

5. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides Benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the Benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the Plan's Allowable Expense.

6. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, Benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.

7. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the Benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

Section G. Coordination With Government And Other Programs.

1. **Medicaid**: If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first and Medicaid or the State Children's Health Insurance Program (CHIP) pays second.

2. **TRICARE**: If an individual is covered by both this Plan and the TRICARE Program that provides health care services to Uniformed Service members, Retirees and their families worldwide, this Plan pays first and TRICARE pays second. For an individual called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this Plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, Benefits are not payable by this Plan.

3. **Veterans Affairs/Military Medical Facility Services**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, Benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is **not** a military service-related illness or injury, Benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowable Expenses.

4. **Motor Vehicle Coverage Required by Law**: If an eligible individual under this Plan is covered for Benefits by both this Plan and any motor vehicle coverage, including but not limited to no-fault, uninsured motorist, underinsured motorist or personal injury protection rider to a motor vehicle liability policy, that motor vehicle coverage pays first, and this Plan pays second. The Plan's benefit coverage is excess to any vehicle insurance (including medical payments coverage/MPC, personal injury protection/PIP, and/or no-fault).

5. **Indian Health Services (IHS):** If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.

6. **Other Coverage Provided by State or Federal Law:** If an eligible individual under this Plan is covered by both this Plan and any other coverage (not already mentioned above) that is provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second.

Section H. Workers' Compensation.

1. This Plan **does not provide** Benefits if the expenses are covered by workers' compensation or occupational disease law. If the individual's employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay Benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. Before such payment will be made, the individual must execute a subrogation and reimbursement agreement acceptable to the Board of Trustees or its designee. However, the failure of the individual to sign such an agreement will not constitute a waiver by the Plan, the Board of Trustees or the Claims Administrator of their rights to recover any payments that the Plan has advanced.

Section I. Third Party Recovery Rules.

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

compensation or another Third Party alleged to be responsible for the injury or illness and/or related medical care expenses.

2. The following provisions set forth the Plan's rights and your obligations in any case where you seek conditional, interim Plan Benefits while you pursue a recovery from workers' compensation or a Third Party who has allegedly caused your injury or illness.

3. The Plan is a self-funded Retiree-only benefit plan. It is not an insurance company, nor is it a for-profit entity. The contributions that fund Plan Benefits do not come from insurance premiums, but instead from limited employer contributions negotiated by the Union, Employee, and Retiree contributions, which must be protected and preserved for the benefit of all Plan Beneficiaries as a whole. Accordingly, the Board of Trustees shall, in their sole and complete discretion, interpret and apply these rules broadly to ensure the maximum Plan recovery in any case, and their interpretation shall be binding on all parties and any reviewing court or other tribunal.

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

5. "**Third Party**" means the person or organization including workers' compensation and all first-party insurance policies, (e.g., uninsured or underinsured motorist coverage) that is or may be liable or financially responsible for the injuries or Illness and/or related medical care expenses, even if that person is a relative and/or another Participant in this Plan.

6. **"Third Party Recovery**" means any money sought or received by an injured or ill Participant or Dependent (or by anyone on their behalf), as payment to themselves or any other party (including but not limited to a special needs trust, charity, fund, or any other entity), from any source, including workers' compensation and first-party insurance coverage (including but not limited to uninsured and/or underinsured motorist coverage) where the money is sought or received in relation to the Illness or injury (not necessarily for the payment of medical claims). The term Third Party Recovery is not limited to money recovered specifically for medical expenses or to satisfy the Plan's repayment rights under these rules.

7. The Plan's rights under these rules apply no matter how the recovery is labeled or denominated, which label or denomination shall be disregarded when applying these rules. Any issue regarding whether a particular expense is related to a particular Illness or injury shall be resolved by the Board of Trustees, in their sole and complete discretion. Where the Third Party Recovery is not from workers' compensation, the Plan's Third Party Recovery rights herein are limited to 100% of the Third Party Recovery obtained by the Participant or Dependent. Where the injury or illness is work-related, amounts not recovered out of a workers' compensation recovery may be recovered by the Plan directly from the Participant and injured/ill Dependent or any other person or entity holding the proceeds of the Third Party Recovery.

8. **Duty to Cooperate; Liability to Plan for Attorneys' Fees**.

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

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

   (c) Any dispute or controversy regarding application of these rules shall be resolved by an action in the appropriate federal court.

   (d) In any action to resolve any dispute regarding the application of these rules the Plan shall not be required to join any other party (including but not limited to the third party or third-party insurance provider), and shall be entitled to, and the Participant and/or Dependent shall stipulate to, a preliminary injunction preventing the distribution, transfer or dissipation of any Third Party Recovery money identified by the Plan.

9. **Precondition to Eligibility for Benefits and Plan Payment of Benefits**.

(a) The right of any person to receive Plan Benefits is subject to and conditioned on that person's, and his or her attorney's or other representative's, full agreement and acquiescence to every term of the Plan, including the terms of the Repayment Agreement described below and these Third Party Recovery Rules.

(b) If the Participant or Dependent hires an attorney in relation to the illness or injury, he or she agrees to obtain the full cooperation and agreement of the attorney to fully comply with these rules and the Repayment Agreement.

(c) Before the Plan pays any Benefits, and in order for any person to be eligible for Benefits under these Third Party Recovery Rules, the Participant and any injured or ill Dependent seeking Plan Benefits must sign a separate agreement with the Plan, in form and substance acceptable to the Plan, to (jointly and severally) repay the Plan and otherwise fully comply with these Third Party Recovery Rules (the "Repayment Agreement"). The Repayment Agreement is a contract enforceable as a matter of state law against the Participant, the Dependent, and the law firm or attorney representing them, independently from, and in addition to, enforcement of the Repayment Agreement as a Plan document, enforcement of the terms of this Plan under any applicable state or federal law, or enforcement of the Plan's rights in equity.

(d) Before the Plan pays any Benefits and in order for the Participant or Dependent to be or remain eligible for Benefits, the Participant and injured or ill Dependent, and their attorney, must sign the Repayment Agreement in form and substance acceptable to the Plan and as amended by the Plan from time to time, promising to repay the Plan under these Rules and fully abide by them.

(e) In any case where a Participant or Dependent, or an attorney or other representative, fails to fully acknowledge, comply and cooperate with these Third Party Recovery Rules, including prompt, full and accurate communication and responses to the Plan and its representatives, such Participant and each and every Dependent of such Participant shall have all Plan Benefits suspended pending full recovery by the Plan, subject to the Board of Trustees' discretion to waive benefit suspension for good cause shown as determined in the sole discretion of the Board of Trustees. The Board of Trustees, in its sole discretion, may, in addition to any other rights the Plan may have, deduct or offset the money it is due (including attorneys' fees and costs and interest described in Section J. 8(b) above) from future Benefits to the Participant and/or any of his Dependents.

(f) If the injured or ill person is a minor, the minor's parent/legal guardian must sign the required Repayment Agreement. By doing so, the parent/legal guardian certifies that he or she is the parent and/or legal guardian of the minor, has fully explained this Agreement to the minor, will take whatever legal action is required on behalf of the minor to make the Repayment Agreement and these rules legal and binding on the minor, and personally guarantee the Plan's Third Party Recovery rights.

(g) A Participant and injured or ill Dependent seeking Benefits in circumstances described in these Third Party Recovery Rules shall be required to execute a Stipulation and Order for Entry of Preliminary Injunction, on a form prescribed by the Plan, which the Plan may file in court at any time the Plan determines that there has been a failure to fully cooperate and comply with the these rules.

10. **Plan Rights**. The Plan's Third Party Recovery Rights are cumulative and may be asserted by the Plan singly, together, or in any combination as the Board of Trustees, in its sole discretion, determines. The Plan's Third Party Recovery Rights include but are not limited to:

(a) **Lien and Express Trust Rights**. To the extent the Participant or Dependent, their attorney, agent, assignee, trust or any other person or entity on behalf of such Participant or Dependent, recovers money from a Third Party, or as a result of workers' compensation, in relation to an injury or illness for which the Plan has paid or later pays Benefits, the Plan shall have a first priority lien on the amounts so recovered. The Participant or Dependent, their attorney, agent, assignee, trust or any other person or entity on behalf of such Participant or Dependent, holds all such money in trust, as expressly provided hereby, for the Plan and must pay such amount, up to the amount of claims the Plan has paid to date (or as of such later date on which the Plan demands reimbursement for additional or other claims paid) to the Plan within ten (10) days of receipt by such entity or person (or demand by the Plan). Prior to payment to the Plan, any person holding or controlling such funds is a fiduciary as to the Plan's assets thus held. All funds, payments, contributions and obligations owed to the Plan are Plan Assets, whether or not the same have been delivered to the Plan.

(b) **Repayment Rights**. The Participant or Dependent, their attorney, agent, assignee, trust or any other person or entity on behalf of such Participant or Dependent, is obligated to fully reimburse the Plan to the extent of any recovery they have received from a Third Party, or workers' compensation, or other similar sources, in relation to an injury or illness for which the Plan has paid or later pays Benefits.

(c) **Assignment of Funds**. Any funds due to the Plan as the result of a Third Party's conduct or financial responsibility hereunder shall be deemed assigned to the Plan prior to receipt by the Participant or Dependent,

or their agent or attorney, or payment to any person, provider or entity on behalf of the injured person. Such funds, thus assigned, are the sole property of the Plan and any party taking any action contrary to the Plan's rights to such funds does so in violation of such rights. Any party or entity in possession of such funds following such assignment to the Plan holds such funds in trust, and as a fiduciary, for the exclusive benefit of the Plan and upon demand of the Plan must immediately transfer all such amounts to the Plan.

(d) **Subrogation**. The Plan has a right of subrogation to the extent of all Benefits paid under the Plan as a result of a Third Party's wrongful act or negligence that allegedly causes an injury to the Participant or Dependent. The Plan has the right but not the obligation to assert any and all rights the Participant or Dependent might have against the Third Party in order to recover an amount equal to the amount of Benefits paid under the Plan. The Plan's subrogation rights also apply to workers' compensation injuries or illnesses for which the Plan paid Benefits. The Plan is subrogated and succeeds to the Participant's or Dependent's rights, which rights are assigned to the Plan.

11. **Rejection of Make Whole, Common Fund, and other doctrines**. The Plan's Third Party Recovery Rights, as described herein, apply without regard to whether the amount recovered is sufficient to make the injured party whole, and without reduction for costs or fees incurred by the injured party in obtaining such recovery. The "Make Whole," "Common Fund," and any other doctrine or equitable defense having the effect of reducing the Plan's recoveries under these rules, are hereby specifically rejected by the Plan and by any Participant or Dependent seeking Plan Benefits. Should any court or other competent tribunal rule that, despite this provision, any such doctrine or defense applies to cause any reduction in the Plan's recovery under these rules, the contractual obligations to the Plan owed by the Participant, the Dependent and their attorney under the Repayment Agreement shall be increased in an equal amount.

12. **Future Claims**. The Plan's Third Party Recovery rights extend to additional Benefits paid after receiving an initial (or multiple) reimbursements under these Rules to the extent of any claims incurred after the date of such reimbursement; future claims by the Plan under these rules are not extinguished by resolution of past claims. Insistence by any party that the Plan waive future claims to receive reimbursement under these rules shall be deemed a failure to cooperate.

13. **Workers' Compensation Claims**. Regarding workers' compensation claims, the Participant or Dependent must timely and diligently make and keep appointments, file papers, including claim forms, attend hearings and pursue all appeals available, including to the extent provided by any separate Plan policies that apply, and otherwise fully cooperate and act in good faith with others in connection with such workers' compensation claims. If workers' compensation Benefits are not available for a work-related injury due to any failure of the Participant or Dependent to comply with this provision, or misconduct of the injured person at the time of injury or during the course of subsequent proceedings, the Plan's Third Party Recovery Rights in such cases shall be preserved and enforceable for the recovery of ineligible benefit payments against the Participant and an injured or ill Dependent.

ARTICLE XV. COBRA TEMPORARY CONTINUATION OF COVERAGE

Section A. Continuation Of Health Care Coverage (COBRA).

1. **Entitlement to COBRA Continuation Coverage:** In compliance with a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (commonly called COBRA), eligible Non-Medicare Retirees and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).
2. **Alternatives to COBRA:** Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.
3. Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.
4. **This Plan provides no greater COBRA rights than what is required by law and nothing in this Article is intended to expand a person's COBRA rights.**
5. **COBRA Administrator**: The name, address and telephone number of the COBRA Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is shown in the Quick Reference Chart in the front of this document.

> **IMPORTANT:**
> *This Article serves as a notice to summarize your rights and obligations under the COBRA Continuation Coverage law. It is provided to covered Non-Medicare Retirees, and is intended to inform them (and their covered Dependents, if any) in a summary fashion about COBRA coverage, when it may become available and what needs to be done to protect the right to receive COBRA coverage. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your Spouse take the time to read this Article carefully and be familiar with its contents.*

Section B. Who Is Entitled to COBRA Continuation Coverage, When and For How Long.

1. Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date.
2. Covered Retirees may elect COBRA on behalf of their Spouses and covered parents/legal guardians may elect COBRA for a minor Child.
3. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.
4. **"Qualified Beneficiary"**: Under the law, a Qualified Beneficiary is any Non-Medicare Retiree or the Spouse or Dependent Child of a Non-Medicare Retiree who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A Child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
   (a) A Child of the covered Retiree who is receiving Benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the Retiree's period of coverage, is entitled to the same rights under COBRA as an eligible Dependent Child.
   (b) A person who becomes the new Spouse of an existing COBRA Participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA Participant but is not a "Qualified Beneficiary." This means that if the existing COBRA Participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.
5. **"Qualifying Event":** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect**

COBRA when the covered individual LOSES health care coverage under this Plan. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, then COBRA is not available.

6. The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries		
	Retiree	Spouse	Dependent Child(ren)
Retiree dies.	N/A	36 months	36 months
Retiree becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

Section C. Failure to Elect COBRA Continuation Coverage.

1. In considering whether to elect COBRA, you should take into account that failure to continue your group health coverage will affect your future rights under federal law.

Section D. Special Enrollment Rights.

1. You have special enrollment rights under federal law that allow you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this Article. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Section E. Maximum Period of COBRA Continuation Coverage.

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

Section F. Medicare Entitlement.

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

Section G. Procedure for Notifying the Plan of a Qualifying Event (Very Important Information).

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

2. That written notice should be sent to the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

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

3. Officials of the Retiree's own employer should notify the COBRA Administrator of a Retiree's death or entitlement to Medicare. However, **you or your family should also promptly notify the COBRA Administrator in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Section H. Notices Related to COBRA Continuation Coverage.

1. When:

(a) **your employer notifies the Plan** that your health care coverage has ended because you died, have become entitled to Medicare, or

(b) **you notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the COBRA Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. **Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage.** Under the law, you and/or your covered Dependents will then have only **60 days** from the date of receipt of that notice, to elect COBRA Continuation Coverage.

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

Section I. The COBRA Continuation Coverage That Will Be Provided.

1. If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this Article for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts.
2. If there is a change in the health coverage provided by the Plan to similarly situated Retirees and their families, that same change will apply to your COBRA Continuation Coverage.
3. **Health Coverage Tax Credit (HCTC):** The Trade Act of 2002 created a tax credit (called the Health Coverage Tax Credit or HCTC) for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance including COBRA. While the HCTC expired on January 1, 2014, it was reinstated to be effective for coverage periods through 2019. For more information, visit, www.irs.gov/HCTC.

Section J. Paying for COBRA Continuation Coverage (The Cost of COBRA).

1. Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated Retirees and families (including both the Fund's and Retiree's share), plus an additional 2%.
2. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.
3. Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.
4. **NOTE: You will not receive an invoice (bill) for the initial COBRA premium payment or for the monthly COBRA premium payments. You are responsible for making timely payments for COBRA continuation coverage** to the COBRA Administrator listed on the Quick Reference Chart.

IMPORTANT

- √ **There will be NO invoices or payment reminders for COBRA premium payments.**
- √ **You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator.**
- √ **If you fail to make a periodic COBRA premium payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.**

Section K. Grace Periods.

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

2. After the initial COBRA payment, **subsequent payments** are due on the first day of each month, but there will be **a 30-day grace period** to make those payments. If payments are not made within the 30-day time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Section L. Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage.

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

Section M. Notice of Unavailability of COBRA Coverage.

1. In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the COBRA Administrator an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Section N. Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period.

1. A Spouse and Dependent Child who already have COBRA coverage, and then experience a second qualifying event, may be entitled to extend their COBRA from 18 or 29 months, to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered Retiree, divorce from the covered Retiree, the covered Retiree becoming entitled* to Medicare benefits (under Part A, Part B or both), or a Dependent Child ceasing to be eligible for coverage as a dependent under the group health plan.
2. *NOTE: Medicare entitlement is not a Qualifying Event under this Plan and as a result, Medicare entitlement following a termination of coverage will not extend COBRA to 36 months for Spouses and Dependents who are Qualified Beneficiaries.
3. **Notifying the Plan:** To extend COBRA when a second Qualifying Event occurs, you must notify the COBRA Administrator in writing within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.
4. This extended period of COBRA Continuation Coverage is available to any Child(ren) born to, adopted by or placed for adoption with you (the covered Retiree) during the 18-month period of COBRA Continuation Coverage.
5. In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Section O. Extended COBRA Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period.

1. If, prior to the Qualifying Event or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child is totally and permanently disabled so as to be entitled to Social Security Disability Income Benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).
2. This extension is available only if:
   (a) the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and**
   (b) the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.
3. **Notifying the Plan**: you or another family member need to follow this procedure (to notify the Plan) by sending a written notification to the COBRA Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability

including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the COBRA Administrator before the end of the 18-month COBRA Continuation period.

4. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage may be 50% higher than the cost for coverage during the first 18-month period.

5. The COBRA Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled. In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

REMINDER: You must notify the Plan within 60 days after receiving a disability determination letter from the Social Security Administration. Failure to notify the Plan in a timely fashion may jeopardize your rights to extended COBRA coverage.

Section P. Early Termination of COBRA Continuation Coverage.

1. Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

   (a) The date the amount due for COBRA coverage is not paid **in full and on time**;

   (b) The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;

   (c) The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan. IMPORTANT: The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Plan ends on the date the Qualified Beneficiary is covered under the other group health plan.

   (d) During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled Beneficiary is determined by the Social Security Administration to no longer be disabled;

   (e) The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA Participants under the Plan).

   (f) The date the Fund no longer provides group health coverage to any of its Retirees.

Section Q. Notice of Early Termination of COBRA Continuation Coverage.

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

Section R. No Entitlement to Convert to an Individual Health Plan after COBRA Ends.

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

Section S. COBRA Questions or To Give Notice of Changes in Your Circumstances.

1. If you have any questions about your COBRA rights, please contact the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document.

2. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit their website at www.dol.gov/ebsa. The addresses and phone numbers of Regional and District EBSA offices are available through this website.

3. **Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the COBRA Administrator:**

   (a) within 31 days of a **change in marital status (e.g. marry, divorce)**; or have **a new Dependent Child**; or

   (b) within 60 days of the date you or a covered Dependent Spouse or Child has been determined to be **totally and permanently disabled** by the Social Security Administration; or

   (c) within 60 days if a covered Child **ceases to be a "Dependent Child"** as that term is defined by the Plan; or

(d) promptly if an individual has **changed their address, becomes entitled to Medicare, or is no longer disabled**.

Section T. Appealing an Adverse Determination Related to COBRA

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

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

b) Explain why you disagree with the adverse determination.

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

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

The appeal will be reviewed by the Board of Trustees.

a) **If an appeal is filed with the Plan more than 30 days before the next Board meeting**, the review will occur at the next Board meeting date.

b) **If an appeal is filed with the Plan within 30 days of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.

c) If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

d) After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made. The appeal response will be sent to the address provided by the individual. This concludes the COBRA appeal process.

ARTICLE XVI. GENERAL PROVISIONS & INFORMATION REQUIRED BY ERISA

Section A. Name And Contact Information For The Plan.

Teamsters Security Fund for Southern Nevada - Local 14
2250 South Rancho, Suite 295
Las Vegas, NV 89102-4454
Phone: 1-702-851-8286

Section B. Plan Administrator.

The Board of Trustees for Teamsters Security Fund for Southern Nevada - Local 14
2250 South Rancho, Suite 295
Las Vegas, NV 89102

The Board of Trustees is both the Plan Sponsor and the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan Participants and Beneficiaries in accordance with the requirements of the Employees Retirement Income Security Act of 1974.

Section C. Employer Identification Number (EIN).

88-0087294

Section D. Type Of Plan And Plan Number.

Retiree-only Welfare Benefits Plan including:

1. Medical expense Benefits including hospital and outpatient prescription drugs (502)
2. Dental expense Benefits (502)
3. Vision expense Benefits (502)
4. Life and Accidental Death and Dismemberment Insurance (502)

Section E. Type Of Administration.

1. The Medical PPO plan, Dental PPO plan, and Vision PPO plan Benefits are self-funded group health plan benefits with contributions from contributing employers, Eligible Retirees and COBRA Beneficiaries held in a Trust which is used to pay Plan Benefits. Third Party Administrators pay Benefits out of Trust assets. The contact information for the Third Party Administrators (listed below) is on the Quick Reference Chart in the front of this document.
2. Teamsters Security Fund for Southern Nevada - Local 14 contracts with various independent insurance companies (whose name and address are listed on the Quick Reference Chart in the front of this document) to administer the fully insured life and accidental death and dismemberment Benefits of this Plan, and the HMO Dental Plan. Premiums for these insured Benefits are paid out of Trust assets.

Section F. Third Party Administrators.

1. The contact information for the following claims administrators is listed on the Quick Reference Chart in the front of this document.

TYPE OF BENEFIT	THIRD PARTY ADMINISTRATOR
Self-funded Medical PPO Plan Benefits	Zenith American, EnvisionRx PBM, Harmony Healthcare and Anthem
Self-funded Dental PPO Plan Benefits	Delta Dental
Self-funded Vision PPO Plan Benefits	VSP
Insured Dental HMO Plan Benefits	Liberty Dental
Insured Life and Accidental Death and Dismemberment Benefits	ULLICO

The insured benefits noted above are not described in this document and are instead available from the insurance companies.

Section G. Agent For Service Of Legal Process.

1. For disputes arising under the Plan, service of legal process may be made on the Fund's legal counsel at the address below, or on the Plan Trustees:

   J. Kenny Kelley, Esq.
   Ryan Rapp Pacheo & Kelley, PLC
   3200 North Central Avenue, Suite 2250
   Phoenix, AZ 85012
   Phone: 602-280-1000
   Fax: 602-265-1495

2. For disputes arising under those portions of the Plan that are fully insured, service of legal process may be made upon those insurers at their address listed on the Quick Reference Chart in the front of this document, or upon the supervisory official of the Nevada Division of Insurance.

Section H. Plan Trustees.

1. The Trustees of the Plan are:

UNION TRUSTEES	MANAGEMENT TRUSTEES
Fred Horvath (Chairman) Teamsters Local Union 14 8951 West Sahara Avenue, Suite 100 Las Vegas NV 89117	Sally Ihmels (Co-Chair) Assistant City Manager City of North Las Vegas 2250 Las Vegas Blvd. North, Suite #600 North Las Vegas, NV 89030
Grant Davis Teamsters Local 14 8951 West Sahara Avenue, Suite 100 Las Vegas NV 89117	J. Douglas Coon Anderson Dairy 801 Searles Avenue Las Vegas, NV 89101
Anthony Freitas Teamsters Local 14 8951 West Sahara Avenue, Suite 100 Las Vegas NV 89117	Jeremy Courval National Director, Employee Relations Southern Glazer's Wine & Spirits 1300 Clay Street, Suite 400 Oakland, CA 94612
Johnny Ortega Teamsters Local 14 8951 West Sahara Avenue, Suite 100 Las Vegas NV 89117	Robert Graham Vice-President of Labor and Employee Relations Reyes Holdings, LLC 6250 North River Road Rosemont, IL 60018
Jason Gateley Teamsters Local Union 14 8951 West Sahara Avenue, Suite 100 Las Vegas NV 89117	Tricia Pavone Las Vegas-Clark County Library District 7060 W. Windmill Lane Las Vegas, NV 89113
Alternate Travis Nelson Teamsters Local Union 14 8951 West Sahara Avenue, Suite 100 Las Vegas NV 89117	*Alternate* Courtney Redsull Employee Benefits Manager City of Henderson –Finance Department 240 Water Street, MSC 122 Henderson, NV 89015
Alternate Kim Spurlock Teamsters Local Union 14 8951 West Sahara Avenue, Suite 100 Las Vegas NV 89117	*Alternate* Bre Beaumier, IPMA-CP Employee Benefits Coordinator City of Henderson –Finance Department 240 Water Street, MSC 122 PO Box 95050 Henderson, NV 890009-5050

Section I. Plan's Requirements For Eligibility And Benefits.

1. The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of Benefits are described in the Eligibility Article in this document. The Benefits provided by the Plan are described in the remaining Articles of this document (as outlined on the Table of Contents).

Section J. Collective Bargaining Agreement And Funding Medium.

1. Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing Benefits to Eligible Persons and defraying reasonable administrative expenses. All self-funded Benefits are provided directly through the Trust Fund.
2. The Plan is financed by Employer contributions pursuant to the Collective Bargaining Agreements. A supplemental source of financing is interest earned on the investment of reserve funds and through voluntary contributions of Participant to retain eligibility.
3. It is recognized that the payments provided for in the Plan can be reimbursed only to the extent that the Plan has available adequate resources for such payments. No contributing Employer has liability, directly or indirectly, to provide the Benefits established hereunder beyond the obligation of the contributing Employer to make contributions as stipulated in its Collective Bargaining Agreement. If at any time the Plan does not have sufficient assets to permit continued payments of Benefits hereunder, nothing contained in the Plan shall be construed as obligating any contributing Employer to make payments or contributions (other than the contributions for which the contributing Employer may be obligated by its Collective Bargaining Agreement) in order to provide Benefits established hereunder. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, any Signatory Association, the Union, any Local Union or any other person or entity of any kind to provide the benefit established hereunder if the Plan does not have sufficient assets to make such payments.

Section K. Plan Year.

1. The Plan's fiscal records are kept on a Calendar Year basis beginning on January 1 and ending on December 31.

Section L. Statement Of ERISA Rights.

1. As a Participant in the **Teamsters Security Fund for Southern Nevada-Local 14 Non-Medicare Retiree Plan**, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:
2. **Receive Information About Your Plan and Benefits**
   (a) Examine, without charge, at the Plan Administrator's office (*the Board of Trustees is the Plan Administrator and their address is listed on the Quick Reference Chart in the front of this document*) and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).
   (b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
   (c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
3. **Continue Group Health Plan Coverage**
   (a) Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event, as described in the COBRA Article. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.
4. **Prudent Actions by Plan Fiduciaries**
   (a) In addition to creating rights for plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Retiree-only benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan Participants and Beneficiaries.
   (b) No one, including your employer, your union, or any other person may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
5. **Enforce Your Rights**

(a) If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules, as discussed in the Claims Filing and Appeals Information Article of this document.

(b) Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

(c) If you have a claim for Benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. See the Plan's Claims Filing and Appeal information on the requirement to appeal a denied claim and exhaust the Plan's appeal process **before** filing a lawsuit.

(d) In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order (QMCSO), you may file suit in Federal court.

(e) If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

6. **Assistance with Your Questions**

(a) If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210.

(b) You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration) at Toll-Free: 1.866.444.EBSA (3272).

Section M. Plan Amendments Or Termination Of Plan.

1. The Board of Trustees reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to Participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

2. The Plan or any coverage under it may be terminated by its Board of Trustees, and new coverages may be added by its Board of Trustees. Upon termination, discontinuance or revocation of participation in the Plan, all elections and reductions in compensation related to the Plan will terminate.

Section N. Allocation And Disposition Of Assets Upon Termination.

1. In order for the Fund to carry out its obligation to provide the maximum possible Benefits to all Participants within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

(a) To terminate any Benefits provided by these Plan Rules.

(b) To alter or postpone the method of payment of any benefit.

(c) To amend or rescind any provision of these Plan Rules.

2. **Termination of Trust Provisions.** The Trust Fund shall remain in full force and effect until terminated by the action of the Trustees. In the event of terminations, the Trustees shall:

(a) Make provision out of the Trust Fund for the payment of expenses incurred up to the date of termination of the Trust and expenses incident to such termination.

(b) Distribute the balance, if any, of the assets of the Trust Fund remaining in the hands of the Trustees in such manner as they determine will carry out the purpose of the Trust, including, but not limited to, the purchase of existing insurance Benefits on a pro rata basis or the transfer of such funds to a successor trust having the same or similar purposes for the benefit of Participants.

(c) Arrange for a final audit and report of their transactions and accounts for the purpose of terminating their Trusteeship.

(d) In any event, upon termination, the Trustees may transfer group insurance policies and the balance, if any, of the assets of the Trust Fund remaining in the hands of the Trustees, or any portion thereof, to the Trustees of another Fund established for the purpose of providing substantially the same or greater group coverage than that contemplated by the Plan.

(e) In no event shall any of the Fund, except for Benefits due, revert to or be recoverable by any Participant, Employer or Union.

Section O. Plan Documents and Reports

You may examine the following documents at the Administrative Office during regular business hours, Monday through Friday, except holidays:

1. Trust Agreement;
2. Collective Bargaining Agreement;
3. Plan Documents, policies and all amendments;
4. Form 5500 or full Annual report filed with the Internal Revenue Service and Department of Labor; and
5. List of Contributing Employers or Employee Associations and addresses

You may also obtain copies of the documents by writing for them and paying the reasonable cost of duplication. You should find out what the charges will be before requesting copies. If you prefer, you can arrange to examine these reports, during business hours, at your local Union office. To make such arrangements, call or write the Administrator at the Administrative Office. A summary of the annual report that gives details of the financial information about the Fund's operation is furnished free of charge to all Participants.

Section P. Statement Of Rights.

1. The Board of Trustees, as Plan Sponsor, intends that the terms of this Plan described in this document, including those relating to coverage and Benefits, are legally enforceable, and that each plan is maintained for the exclusive benefit of Participants and Beneficiaries, as defined by law.

Section Q. No Liability For Practice Of Medicine.

1. The Plan, Board of Trustees, employees, or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Board of Trustees, employees, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Section R. Right Of Plan To Require A Physical Examination.

1. The Plan reserves the right to have the person, who is totally disabled or who has submitted a claim for Benefits and is undergoing treatment under the care of a Physician, to be examined by a Physician selected by the Board of Trustees or its designee at any time during the period that Benefits are extended under this Plan. This right extends to the right and opportunity to request an autopsy or other forensic exam in case of death where it is not forbidden by law. The cost of such an examination will be paid by the Plan.

Section S. Newborns' & Mothers' Health Protection Act (Newborns' Act)

1. This Plan complies with the Newborns' and Mothers' Health Protection Act. See the information described under Maternity services in the Schedule of Medical PPO Plan Benefits chart in this document.

Section T. Anticipation, Alienation, Non-Assignment, Sale Or Transfer.

1. Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale transfer, assignment, pledge, encumbrance, or charge by any person; however, any Retiree may direct that Benefits due him be paid to an institution in which he or his eligible Dependent is hospitalized or to any provider of medical services or supplies in consideration for medical and hospital services or to be rendered.
2. Coverage and your rights under this Plan may not be assigned. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered. A direction to pay a provider is not an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, and is not an assignment of any legal or equitable right to institute any court proceeding.

Section U. Disputes.

1. No Retiree, eligible Dependent, Beneficiary or other person shall have any right or claim to Benefits under the Plan or any right to claim to payments from the Plan other than as specified in this Plan, the rules of the Plan and the provisions of the Trust Agreement. Any dispute as to the eligibility, type, amount of duration of such Benefits or any right or claim to payments from the Plan shall be resolved by the Board of Trustees, or its Agent, under and pursuant to the Plan and its decision shall be final and binding upon all parties thereto, subject only to such judicial review as may be provided by ERISA.

Section V. Benefits After Death.

1. In the event of the death of the Retiree before all amounts payable under the Plan have been paid, the Plan may pay any amount to any person or institution determined by the Plan to be equitably entitled to receive it.

2. The remainder of any Benefits will be paid to the eligible Retiree's Beneficiary or to the Retiree's estate, as the Board of Trustees in its sole discretion may decide. If the Beneficiary is unable to give a valid release or if Benefits unpaid at the time of the Retiree's death are not more than $1,000, Benefits of up to $1,000 may be paid to any relative of the Retiree who is determined to be entitled to the Benefits. Any payment in accordance with this provision will discharge the obligation of the Plan to the extent of such payment.

Section W. Reduction Of Benefits.

1. The Trustees have authority to adjust and/or reduce Benefits available to Retirees on whose behalf contributions are insufficient to cover the full current cost of Benefits, as determined in the sole and complete discretion of the Trustees. Such an adjustment and/or reduction may include, but is not limited to, elimination of dental, vision or any other item of coverage, higher Deductibles, Copays, etc. The basis for such adjustment and/or reduction may include, but is not limited to, the failure of a negotiated contribution rate to keep pace with the costs of Benefits, or an Retiree's failure to pay, or authorize his employer to transfer, the Retiree's portion of contributions.

Section X. Trust Agreement.

1. The provisions of this Plan Document are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of this Plan Document and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

Section Y. Trustee Discretion.

1. The Trustees have the exclusive right, power and authority, in their sole and absolute discretion, to administer, apply and interpret this Plan and all other documents that describe the Plan and Trust Fund. The Trustees may decide all matters arising in connection with the operation and administration of the Plan. Plan Benefits shall be paid only if the Trustees, in their discretion, decide that a Participant is entitled to them. Except as described in the claims and appeals procedures, all determinations made by the Trustee with respect to any matter arising with regard to Plan Benefits will be final and binding on all concerned. Any judicial review of any Trustee decision must be done in deference to the Trustees' decision. Without limiting the generality of the foregoing, it is the express intent of the Plan that the Trustees shall have sole and absolute discretionary authority:

   (a) To take all actions and make all decisions with respect to the eligibility for, and the amount of, Benefits reimbursed under the Plan;

   (b) To formulate, interpret and apply rules, regulations, interpretations, practices and policies necessary to administer the Plan in accordance with its terms;

   (c) To decide questions, including legal or factual questions, relating to the calculation and payments of Benefits under the Plan;

   (d) To resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other Plan documents;

   (e) To process, and approve or deny, benefit claims and rule on any benefit Exclusions; and

   (f) All determinations made by the Trustees with respect to any matter arising under the Plan and any other Plan document shall be final and binding on all parties.

Section Z. Claims Payments Made In Error.

1. If the Plan pays Benefits for or on behalf of a Retiree or Dependent, when the Retiree or Dependent is not in fact eligible or entitled to the Benefits or if the Plan otherwise mistakenly pays Benefits, the Retiree or Dependent will promptly reimburse the Plan in full for the amount paid in error. The Trustees, in their sole discretion, may deduct or offset any erroneous payment from future Benefits, and/or cancel eligibility for the Retiree and/or all his/her/their Dependents

(which shall not be a COBRA qualifying event). If the Plan files any legal action against the Participant or Dependent(s) to recover any erroneous payment, the Participant will pay all attorneys' fees and costs of the Plan, whether or not such an action proceeds to judgment.

Section AA. Secondary Coverage.

1. Participants who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Participant incurring costs, 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.
2. A provider that accepts the payment from the Plan will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Participant and (ii) it shall not "balance bill" a Participant for any amount billed but not paid by the Plan.

Section BB. Information You Or Your Dependents Must Furnish To The Plan (Very Important Information).

1. In addition to information you must furnish in support of any claim for Plan Benefits under this Plan, you or your covered Dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan.
2. Failure to give this Plan a timely notice (as noted above) may cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or may result in a Participant's liability to the Plan if any Benefits are paid to an ineligible person.
3. Submit such information in writing to the Administrative Office at their address shown in the Quick Reference Chart in the front of this document. The information needed and timeframes for submitting such information are outlined below. See also the COBRA Article for special timeframes applicable to those Benefits:

Type of Information Needed	Date Information is to be Submitted to the Plan as Soon as Possible and:
• Change of name or address or the existence of other health care coverage for any covered person.	Not later than 60 days after the change or addition of other coverage.
• Marriage, divorce, legal separation, addition of a new Dependent, death of any covered person.	Within 31days
• Covered Dependent (Spouse or Child) becomes disabled or is no longer disabled.	Within 31 days of the date the person becomes disabled or is no longer disabled.
• Covered Child ceases to be a Dependent as defined by this Plan (*e.g.* over the limiting age of the Plan, etc.)	Within 60 days of the date the Child is no longer considered a Dependent.
• Receipt of a determination of disability from the Social Security Administration (SSA) or a determination an individual is no longer disabled according to SSA. • Medicare enrollment or disenrollment.	See the COBRA Article for timeframe.

Section CC. Headings, Font And Style Do Not Modify Plan Provisions.

1. The headings of Articles, sections and subsections and text appearing in **bold** or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the convenience of the reader. The headings are **not** part of the substantive text of any provision, and they **should not be construed to modify the text of any substantive provision in any way**.

Section DD. HIPAA: Use And Disclosure Of Protected Health Information.

1. Effective April 14, 2003, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like the **Teamsters Security Fund for Southern Nevada - Local 14** (hereafter in this section referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

2. The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

3. **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability Benefits, work-related illness/injury, sick leave, Family and Medical leave (FMLA), life insurance, drug testing, etc.

4. A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is also available from the Administrative Office. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

5. The Plan, and the Plan Sponsor (the Board of Trustees of the Teamsters Security Fund for Southern Nevada - Local 14), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor**.

6. Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

7. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

   (a) **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

   (b) **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan Benefits with activities that include, but are not limited to, the following:

      1) Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and Copayments as determined for an individual's claim), and establishing Employee/Retiree contributions for coverage;

      2) Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of Benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;

      3) Medical necessity reviews, reviews of appropriateness of care or justification of charges, Utilization Review and Case Management, including precertification, concurrent review and/or retrospective review.

   (c) **Health Care Operations** includes, but is not limited to:

      1) Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

      2) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

      3) Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health Benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

      4) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

      5) Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA

Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

6) Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

8. **When an Authorization Form is Needed:** Generally the Plan will require that you sign a valid authorization form (available from the Administrative Office) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

9. **The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

   (a) Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,

   (b) Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of Benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.

   (c) Not use or disclose the information for employment-related actions and decisions,

   (d) Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).

   (e) Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,

   (f) Make PHI available to the individual in accordance with the access requirements of HIPAA,

   (g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,

   (h) Make available the information required to provide an accounting of PHI disclosures,

   (i) Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and

   (j) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

   (k) If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

10. **In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained** in accordance with HIPAA, only the following Employees or classes of Employees may be given access to use and disclose PHI:

    (a) Business Associates under contract to the Plan including but not limited to the group health Plan Benefits administration staff of the Administrative Office, medical PPO plan preferred provider organization network(s), Utilization Review and Case Management Company, Behavioral Health Program, and prescription drug program administrator.

    (b) The persons described in section (a) above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. **Issues of noncompliance** (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer whose address and phone number are listed on the Quick Reference Chart in the front of this document.

11. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

    (a) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,

    (b) Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

    (c) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

(d) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

ARTICLE XVII. DEFINITIONS

Section A. Definitions.

The following are Definitions (in alphabetical order) of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These Definitions do not, and should not be interpreted to, extend coverage under the Plan. Certain Definitions pertaining to claims administration and claim appeals are found in the Claim Filing and Appeals Information Article of this document.

1. **Accident:** an unexpected, sudden and unforeseen event occurring as a result of an external or extrinsic source that is not work-related.

2. **Active Employee Plan**: The plan provided by the Teamsters Security Fund for Southern Nevada – Local 14 for Active Employees and their eligible Dependents. Non-Medicare Retirees must have been enrolled in the Active Employee Plan or in COBRA for 90 of the 120 months immediately before Retirement in order to be eligible for benefits under This Plan. See the Eligibility section for details.

3. **Acupuncture:** A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

4. **Acute Rehabilitation:** See Rehabilitation.

5. **Administrative Office:** The person, firm and/or company designated by the Board of Trustees to handle the daily administrative duties of the Plan including eligibility and payment of Plan Benefits. The contact information for the Administrative Office is listed on the Quick Reference Chart in the front of this document.

6. **Adverse Benefit Determination:** See the Claim Filing and Appeal Information Article for the Definition.

7. **Allowable Expense**: means the amount this Plan allows as payment for eligible Medically Necessary services or supplies. This Plan may not allow payment for certain services or supplies even if such services or supplies are Medically Necessary if a Plan limitation or exclusion applies. The Allowable Expense amount is determined by the Board of Trustees or its designee to be the **lowest** of:

   (a) **With respect to an In-Network provider** (PPO network Health Care provider/facility or Health Services Coalition (HSC) provider/facility), the negotiated fee/rate set forth in the agreement between the participating network Health Care provider/facility and the PPO network or the Plan; **or**

   (b) **With respect to a Non-Network provider**, Allowable Expense amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network providers. Note that **for non-contracted (non-network) hospital services** the allowable expense amount is capped at the lowest HSC contracted rate, amount or schedule, or such other rate, amount, schedule or percentage that is the lowest "reasonable amount" that complies with the requirements of PHSA Section 2719A and related federal guidance. **For non-contracted Dental plan services**, the Dental plan claims administrator maintains the schedule that the Dental Plan has determined it will allow for eligible medically necessary dental services or supplies performed by non-network dental providers. For non-network Behavioral Health providers, the Behavioral Health Program maintains the schedule that they have determined they will allow for eligible medically necessary behavioral health services performed by non-network behavioral health providers.

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

   (c) For an In-Network Health Care Provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowable Expense amount under this Plan is the **negotiated fee/rate** that would have been payable by the Plan had the claim been processed as an In-Network claim; **or**

   (d) The Health Care or Dental Care Provider's/facility's actual **billed charge**.

   The Plan will not always pay Benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is

because the Plan covers only the "Allowable Expense" amount for health care services or supplies, as determined in the sole, exclusive and final judgment of the Board of Trustees or its designee.

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

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted Allowable Expense amount. Such negotiation may be performed by the Board of Trustees or its designee. A designee may include, but is not limited to, a Utilization Review and Case Management Company, Administrative Office, Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowable Expense" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, in-network/non-network plan design, and any Special Reimbursement Provisions adopted by the Plan.

See the Definition of **emergency services** in this Definitions Article.

NOTE: Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. If you use a non-network provider you may be balance billed by that provider.

8. **Ambulance, Professional Ambulance Service:** means a ground motor vehicle, helicopter (rotorcraft), airplane (fixed wing) or boat that is
   a) licensed or certified for emergency patient transportation by the jurisdiction in which it operates; and
   b) is specifically designed, constructed, modified and equipped with the intention to provide basic life support, intermediate life support, advanced life support, or mobile intensive care unit services by appropriately licensed and certified medical professionals; and
   c) provides medical transport services for persons who are seriously ill, injured, wounded, or otherwise incapacitated or helpless and in need of immediate medical transportation; or
   d) are unable to be transported between health care facilities in other than an ambulance (such as transport of an inpatient between hospitals to obtain a radiology procedure or transport from a hospital to a skilled nursing facility).

   Non-emergency medical transportation services include transportation of individuals who cannot use public or private transportation because of their Medically Necessary requirement to be positioned in a wheelchair or stretcher. Non-emergency medical transportation services are payable by this Plan when pre-approved by the UR Company.

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

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

10. **Ancillary Services:**

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;

- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary.

11. **Anesthesia:** The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g. general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g. regional or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

12. **Applied Behavior Analysis (ABA) Therapy:** is the design, implementation, and evaluation of environmental modifications to attempt to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior. ABA strives to improve speech and social interaction skills and reduce disruptive behavior and includes instruction in a range of skills including speech, motor and socialization. ABA Therapy is a technique that some use for individuals diagnosed with Autism Spectrum Disorder (that refers to disorders defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) manual as autistic disorder, Asperger's syndrome or pervasive developmental disorder).

13. **Appropriate:** See the Definition of Medically Necessary for the Definition of Appropriate as it applies to medical services that are Medically Necessary.

14. **Assistant Surgeon:** An assistant surgeon is also referred to as an assistant at surgery or first assistant. A person who functions as an assistant surgeon actively assists the Physician in charge of a surgical case (the surgeon) in performing a surgical procedure. This plan allows payment of an assistant surgeon under the following conditions:
    (a) the individual functioning as an assistant surgeon is properly licensed as a Physician, Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, Registered Nurse First Assistant (RNFA) or Certified Surgical Assistant (CSA, SA-C), but not an employee of a hospital or surgical facility or a medical student, intern or other trainee; and
    (b) the use of an assistant surgeon(s) is determined by the Board of Trustees or its designee to be Medically Necessary; and
    (c) the assistant surgeon actively participated in the surgical procedure (was not stand-by).

15. **Authorization/Authorized:** means the approval given by the Plan's Utilization Review and Case Management Company, or Prescription Drug Program, or Administrative Office for a service that requires preapproval/preauthorization, such as for an elective hospital admission, certain drugs or certain dental services. See the Utilization Review and Case Management Article for more details.

16. **Authorized Representative:** See the Claim Filing and Appeal Information Article for the Definition.

17. **Balance Billing**: A bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowable Expenses and what the provider actually charged (the billed charges). Amounts associated with balance billing **are not covered** by this Plan, even if the Plan's Out-of-Pocket Limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's Definition of Allowable Expense. Remember, amounts exceeding the Allowable Expense do not count toward the Plan's Out-of-Pocket Limit and may result in balance billing to you. **Out-of-Network Health Care Providers commonly engage in balance billing**. This means a plan Participant may be billed for any balance that may be due in addition to the amount payable by the Plan. Typically, In-Network providers do not balance bill except in situations of third party liability claims. **Generally, you can avoid balance billing by using In-Network providers.**

18. **Behavioral Health Disorder:** Behavioral Health is an umbrella term that refers to mental health and/or substance use. A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral health disorder includes, among other things, depression, schizophrenia, and substance use and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by Behavioral Health Practitioners as defined in this Article. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical PPO Plan Exclusions Article of this document. See also the Definitions of Chemical Dependency and Substance Use.

19. **Behavioral Health Practitioners:** A psychiatrist, psychologist, a mental health or substance use counselor or social worker who has a Master's degree, or a nurse practitioner in independent practice who is qualified to perform behavioral health counseling and, who is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

20. **Behavioral Health Treatment:** Behavioral Health Treatment includes outpatient visits and inpatient services (including room and board given by a Behavioral Health Treatment Facility or area of a Hospital that provides behavioral or mental health or Substance Use treatment) for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the Illness that is identified under the DSM code is considered a Behavioral Health Treatment for the purposes of this Plan.

21. **Behavioral Health Treatment Facility:** A specialized facility that is established, equipped, operated and staffed primarily for the purpose of providing a program for diagnosis, evaluation and effective treatment of Behavioral Health Disorders and which fully meets one of the following two tests:
    (a) It is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
    (b) Where licensing is not required, it meets all of the following requirements: has at least one Physician on staff or on call and provides skilled nursing care by licensed Nurses under the direction of a full-time Registered Nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological and social needs of the patient.

22. **Benefit, Benefit Payment, Plan Benefit**: The amount of money payable for a claim, based on the Allowable Expense, after calculation of all Deductibles, Coinsurance and Copayments, and after determination of the Plan's Exclusions, limitations and maximums.

23. **Birth (or Birthing) Center:** A specialized facility that is primarily a place for delivery of Children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:
    (a) It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
    (b) Where licensing is not required, it meets all of the following requirements:
        1) is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate postpartum care, and care of a Child born at the center.
        2) is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
        3) has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
        4) provides at least two beds or two birthing rooms.
        5) is operated under the full-time supervision of a licensed Physician, Registered Nurse (RN) or Certified Nurse Midwife.
        6) has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
        7) has trained personnel and necessary equipment to handle emergency situations.
        8) has immediate access to a blood bank or blood supplies.
        9) has the capacity to administer local anesthetic and to perform minor Surgery.
        10) maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.
        11) is expected to discharge or transfer patients within 48 hours following delivery; and
        12) is accredited by the American Association of Birth Centers (AABC).
    (c) A Birth (or Birthing) Center that is part of a Hospital, as defined in this Article, will be considered to be a Birth (or Birthing) Center for the purposes of this Plan.

24. **Board of Trustees:** See the Definition of Plan Administrator.

25. **Breastfeeding/Lactation Educator**: is a provider who is currently certified as a lactation consultant by the International Board of Lactation Consultant Examiners (IBLCE). If not IBLCE certified, the provider MUST be a licensed, registered, or certified health care professional with referenced experience and training in lactation management. Breastfeeding/lactation educators help mothers initiate or maintain lactation and provide assessment, planning, intervention, and evaluation for optimal breastfeeding, working in conjunction with the mother's physician, licensed or certified midwife and/or baby's pediatrician.

26. **Calendar Year:** The 12-month period beginning January 1 and ending December 31. See also the Definitions of Plan Year. For the Medical program, all annual Deductibles, Coinsurance Maximum and Annual Maximum Plan Benefits are determined during the Calendar Year.

27. **Cardiac Rehabilitation**: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications in order to limit further cardiac damage and reduce the risk of death. Patients are to continue at home, the exercise and educational techniques they learn in this program. See the Schedule of Medical PPO Plan Benefits for information on when cardiac rehabilitation services are payable.

28. **Case Management:** A process, administered by the Utilization Review and Case Management Company, in which its medical professionals work with the patient, family, caregivers, Health Care Providers, Administrative Office and the Fund to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers.

29. **Certified Surgical Assistant (CSA, SA-C)**: A person who is at least a high school graduate and who has successfully passed a national surgical assistant program. A CSA does not typically hold a valid healthcare license as a RN, Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife, Podiatrist, Dentist, MD or DO. A CSA may or may not be required to be licensed by a state agency. A CSA assists the primary surgeon with a surgical procedure in the operating room and is not an employee of a health care facility. The expenses for services of a CSA may be payable by this Plan, including but not limited to designation as a Certified Surgical Assistant (CSA, SA-C), Certified Surgical Technologist (CST), Certified First Assistant (CFA), Certified Surgical Technologist (CST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT) **only IF** the use of an assistant surgeon is Medically Necessary.

30. **Chemical Dependency:** This is another term for Substance Use/Substance Use Disorder. See also the Definitions of Behavioral Health Disorders and Substance Use Disorder.

31. **Child(ren):** See the Definition of Dependent Child(ren).

32. **Chiropractor:** A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license.

33. **Claim, Claimant:** See the Claim Filing and Appeal Information Article for the Definition.

34. **Claims Administrator:** The independent person or company retained by the Plan to administer the claim processing and payment responsibilities and other administration or accounting services as specific by the Plan. The Claims Administrators are listed on the Quick Reference Chart in the front of this document.

35. **COBRA:** means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and refers to temporary continuation of health care coverage. See the COBRA Article of this document for more information.

36. **Coinsurance:** That portion of Eligible Medical or Dental Expenses for which the covered person has financial responsibility to pay. In many instances, the Covered Individual is responsible for paying a fixed percentage of covered expenses after the Plan's Deductible has been met. Coinsurance amounts are listed in the Schedule of Medical PPO Plan Benefits or Schedule of Dental PPO Plan Benefits.

37. **Compound Drugs**: See the Definition of Prescription Drugs.

38. **Concurrent Care Claim:** See the Claim Filing and Appeal Information Article for the Definition.

39. **Concurrent Review:** A managed care program designed to assure that Hospitalization and Health Care Facility admissions and length of stay, surgery and other health care services are Medically Necessary by having the Utilization Review and Case Management (UR/CM) Company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Health Care Facility. Also called Continued Stay Review.

40. **Convalescent Care Facility:** See the Definition of Skilled Nursing Facility.

41. **Coordination of Benefits (COB):** The rules and procedures applicable to determination of how Plan Benefits are payable when a person is covered by two or more health care plans. See also the Coordination of Benefits Article.

42. **Copayment, Copay:** The fixed dollar amount you are responsible for paying when you incur an eligible Health care expense for certain services. The services with a Copay are listed on the Schedule of Medical PPO Plan Benefits in this document.

43. **Corrective Appliances:** The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the Definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

44. **Cosmetic Surgery or Treatment:** Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Board of Trustees or its designee.

45. **Cost-Efficient:** See the Definition of Medically Necessary for the Definition of Cost-Efficient as it applies to medical services that are Medically Necessary.

46. **Cost-sharing:** A term to mean the amount of money a plan participant is to pay toward a service or item, versus the amount of money the Plan is to pay. Plans typically have three different types of cost-sharing provisions: Deductibles, Copayments/Copays and Coinsurance, although not all plans feature each of these types of cost-sharing. It is common to have a Plan change the amount of its cost-sharing provisions at least once each 12 months (more often if necessary). Cost-sharing does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under the plan.

47. **Covered Individual:** Any Non-Medicare Retiree and that person's eligible Spouse or Dependent Child (as these terms are defined in the Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan. A covered individual is also referred to as a Plan Participant.

48. **Custodial Care:** Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care or in conjunction with covered home health services. "Activities of Daily Living" means activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

49. **Days (as relates to claim filing and appeals):** See the Claim Filing and Appeal Information Article for the Definition.

50. **Deductible:** The amount of Eligible Medical PPO Plan or Dental PPO Plan Expenses you are responsible for paying before the Plan begins to pay Benefits. The amount of Deductibles is discussed in the Schedule of Medical PPO Plan Benefits and Dental PPO Plan Benefits Articles of this document.

51. **Dental:** As used in this document, Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics. Dental includes outpatient prescription drugs prescribed by a Dentist, Physician or Health Care Practitioner for a dental purpose such as fluoride tablets. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies are **not covered** under the medical expense coverage of the Plan unless the Plan specifically indicates otherwise in the Schedule of Medical PPO Plan Benefits.

52. **Dental Care Provider:** A Dentist, or Dental Hygienist or other Health Care Practitioner or Nurse as those terms are specifically defined in this Article of the document, who is legally licensed and who is a Dentist or performs services under the direction of a licensed Dentist; and acts within the scope of his or her license.

53. **Dental Subspecialty Areas:**

Subspecialty	Services related to the diagnosis, treatment or prevention of diseases related to:
Endodontics	the dental pulp and its surrounding tissues.
Implantology	attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	extractions and surgical procedures of the mouth.
Orthodontics	abnormally positioned or aligned teeth.
Pedodontics	treatment of dental problems of Children.
Periodontics	structures that support the teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).
Prosthodontics	construction of artificial appliances for the mouth (Bridges, Dentures, Crowns).

54. **Dental Hygienist:** A person who is trained and legally licensed and authorized to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed Dentist, and who acts within the scope of his or her license.

55. **Dentist:** A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of Dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

56. **Dependent:** Any of the following individuals: Dependent Child(ren), or Spouse, as those terms are defined in this document. See also the Definition of Dependent Child, and Spouse.

57. **Dependent Child(ren):**

(a) For the purposes of this Plan, a Dependent Child is any of the Employee/Retiree Children listed below who are under the age of 26 (whether married or unmarried):

1) **Biological son or daughter** (proof of relationship and age will be required).

2) **Stepson or stepdaughter** (proof of relationship and age will be required).

3) **Legally adopted Child or Child placed for adoption** with the Employee/Retiree (proof of adoption or placement for adoption and age will be required). Placed for adoption means the assumption and retention by the Employee/Retiree of a legal obligation for total or partial support of such Child in anticipation of adoption of such Child. The Child's placement for adoption terminates upon the termination of such legal obligation.

4) A Child named as an "alternate recipient" under a **Qualified Medical Child Support Order (QMCSO)**.

(b) **Additional Dependent Children.** In addition to the Dependent Children defined above, the following individuals are eligible for coverage under the Plan:

1) **Disabled Adult Child:** A Disabled Adult Child may be eligible for Benefits. The Plan will require initial and periodic proof of disability. You will have 31 days from the date of the request to provide this proof to the Administrative Office before the Child is determined to be ineligible. The Plan may require, at reasonable times during the two years following the Child's attainment of the limiting age, subsequent proof of the Child's incapacity and dependency. After the two year period, the Plan may require additional proof of the incapacity and dependency once a year.

To be eligible as a Disabled Adult Child, the individual must meet all of the following eligibility requirements:

i. is an **unmarried** Dependent Child (as defined above) of a covered Retiree or Spouse; and

ii. is **age 26 or older**; and

iii. is **permanently and totally disabled** (for example the disability has lasted 12 months, is expected to last 12 months, or is expected to result in death); and

iv. has a **disability that causes the individual to be incapable of self-sustaining employment** (substantial gainful employment) **as a result of that Disability**, and is Dependent chiefly on the Retiree or Spouse for support and maintenance; and

v. the **Disability existed prior to attainment of the age that causes a non-disabled Dependent Child's coverage to end under this Plan** (e.g. the Child's 26th birthday); and

vi. **was covered under this Plan on the day before their 26th birthday.**

A child whose coverage has terminated under this Plan due to reaching the age limit, is not eligible to re-enroll at a later date as a disabled adult dependent child under this Plan

2) **Child under a Legal Guardianship Order:** An individual under age 26 with respect to whom the Retiree has **legal guardianship** under a court order (proof of guardianship and age will be required)

(c) With the exception of a Dependent Child who is permanently and totally disabled prior to age 26, coverage will terminate at the **end of the month in which the individual attains age 26** (unless the individual meets the Definition of a Disabled Adult Child. See also the termination provisions for Dependent Children listed in the Eligibility Article of this document.

(d) **The following individuals are not eligible under the Plan:** foster Child, a Spouse of a Dependent Child (e.g. Retiree's son-in-law or daughter-in-law) or a Child of a Dependent Child (e.g. Retiree's grandchild), Domestic Partner and Domestic Partner Child.

58. **Dietitian:** A Registered Dietitian is a professional who is qualified by training and examination to evaluate people's nutritional health and needs. To be payable under this Plan the dietitian must be credentialed as a Registered Dietitian (RD) by the American Dietetic Association. The Dietitian must be legally licensed where state licensure is required.

59. **Disabled/Disability**: The inability of a person to be self-sufficient as the result of a physically or mentally disabling injury, illness, or condition (such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, or psychosis), **and** the person is permanently and totally disabled in that they are unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months and the condition was diagnosed by a Physician, and accepted by the Board of Trustees or its designee, as a permanent and continuing condition. See also the Definition of Totally Disabled.

60. **Drugs:** See Prescription Drugs.

61. **DSM:** The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard classification of mental disorders used by mental health professionals in the United States. For each disorder included in DSM, a set of diagnostic criteria indicate

what symptoms must be present (and for how long) as well as symptoms, disorders, and conditions that must not be present in order to qualify for a particular diagnosis.

62. **Durable Medical Equipment (DME):** Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable and is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the Definitions of Corrective Appliances, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

63. **Early Retiree:** Individuals who are eligible to participate under the **Teamsters Security Fund for Southern Nevada-Local 14** Plan as a Retiree but who are not yet eligible for Medicare. Early Retiree is also referred to as Non-Medicare Retiree.

64. **Elective Hospital Admission, Service or Procedure:** Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

65. **Eligible Dependent:** Your lawful Spouse and your Dependent Child(ren), as those terms are defined in this Plan. An Eligible Dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan. See the Eligibility Article for further information. Once an Eligible Dependent is duly enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, as described in the Eligibility Article, and that person is a covered Dependent, and remains a covered Dependent until his or her coverage ends in accordance with the terms and provisions of the Plan.

66. **Emergency Care/Emergency:** The Board of Trustees or its designee has the discretion and authority to determine if a service or supply is or should be classified as Emergency Care. Emergency care means health care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a **prudent** layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn Child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction/impairment of any bodily organ or part. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

67. **Emergency Medical Condition:** means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possess an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

68. **Emergency Services**: Means the following:

    1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

    2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

    The Board of Trustees or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

69. **Emergency Surgery:** A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

70. **Employee:** Unless specifically indicated otherwise, when used in this document, Employee refers to a person employed under a Collective Bargaining Agreement between the Employer and the Union and on whose account the Employer is obligated to make, and is making, required contributions to this Plan. Employee can also mean a non-bargaining unit employee of a corporate employer who has signed a non-bargaining unit participation agreement with the Plan. See the Eligibility provisions in the Eligibility Article of this document.

71. **Enroll, Enrollment:** The process of completing and submitting a written enrollment card to the Administrative Office indicating that coverage by the Plan is requested by the Non-Medicare Retiree. A Non-Medicare Retiree may request coverage for an Eligible Dependent only if the Non-Medicare Retiree is or will be covered by the Plan. See the Eligibility Article for details regarding the mechanics of enrollment.

72. **Essential Health Benefits:** means essential health benefits under section 1302(b) of the Affordable Care Act (ACA) and applicable regulations, as may be amended from time to time. Essential Health Benefits include at least the following general categories and the items and services covered within these categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

73. **Exclusions:** Specific conditions, circumstances, and limitations, as set forth in the Medical PPO Plan and Dental PPO Plan Exclusions Articles, for which the Plan does **not** provide Plan Benefits.

74. **Exhausted (in reference to COBRA Continuation Coverage):** For the Definition of Exhausted in connection with COBRA Continuation Coverage as it relates to entitlement to Special Enrollment for coverage, see the section on Special Enrollment in the Eligibility Article.

75. **Experimental and/or Investigational or Unproven:** The Board of Trustees or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational or Unproven.

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

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

    (a) The service or supply is described as an alternative to more conventional therapies in the protocols (the Plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;

    (b) The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;

    (c) In the opinion of the Board of Trustees or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational or unproven; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;

    (d) With respect to services or supplies regulated by the FDA, FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA.

    (e) Under this medical plan, experimental or investigational does not include services when recommended by the Mayo Clinic and received when participating in the Mayo Clinic Complex Care Program. Proton Beam Therapy is not considered experimental or investigational when recommended by and provided at any Mayo Clinic location. Precertification and/or prior authorization requirement is waived for Mayo Clinic when receiving care through the Mayo Clinic Complex Care Program.

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

    (a) Medical or dental records of the covered person;

    (b) The consent document signed, or required to be signed, in order to receive the prescribed service or supply;

    (c) Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;

    (d) Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";

    (e) The published opinions of: the American Medical Association (AMA), or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; clinical policy bulletins of major insurance companies in the US such as Aetna, CIGNA or United Healthcare, or MCG, formerly Milliman Care Guidelines or, the American Dental Association (ADA), with respect to dental services or supplies.

    (f) Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.

(g) The latest edition of "The Medicare National Coverage Determinations Manual."

To determine how to obtain a Precertification of any procedure that might be deemed to be Experimental and/or Investigational or Unproven, see the Precertification Review section of the Utilization Review and Case Management Article.

76. **Extended Care Facility:** See the Definition of Skilled Nursing Facility.

77. **FDA:** The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

78. **Federal Legend Drugs:** See the Definition of Prescription Drugs.

79. **Formulary:** A list of outpatient prescription drug products, including strength and dosages, available for use by Plan Participants. A formulary is also called a Preferred drug list.

80. **Fund/Trust Fund:** means the Teamsters Security Fund for Southern Nevada - Local 14.

81. **Fund Office:** See the Definition of Administrative Office.

82. **Gene Therapy**: is a technique that uses human genes to treat or prevent disease in humans. Gene therapy involves introducing human DNA into an individual to treat a genetic disease (genetically altering the patient's cells to fight their disease). The new DNA usually contains a functioning gene to correct the effects of a disease-causing mutation. The technique can allow doctors to treat a disorder by inserting a gene into an individual's cells instead of using drugs or surgery. There are several approaches to gene therapy, including:
    a) Replacing a mutated "faulty" gene that causes disease with a healthy copy of the gene.
    b) Inactivating, or "knocking out," a mutated "faulty" gene that is not functioning properly.
    c) Introducing a new gene into the body to help fight a disease or cure the disease.

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

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

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

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

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

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

87. **Health Care Facilities:** Specialized health care facility, including a licensed birthing center, ambulatory surgical facility, skilled nursing facility, or licensed hospice facility, as those terms are specifically defined. For non-emergency services: Health Care Facilities are each of the following:

    - A hospital (as defined in section 1861(e) of the Social Security Act);
    - A hospital outpatient department;
    - A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

- An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

88. **Health Care Practitioner:** Acupuncturist, Behavioral Health Practitioner (including licensed psychologist (PhD), clinical specialist psychiatric registered nurse (CSPRN), mental health or substance use counselor or social worker who has a Master's degree), licensed clinical social worker, certified registered nurse anesthetist(CRNA), Chiropractor, Dental Hygienist, Dentist, Nurse (RN, LVN, LPN), Nurse Practitioner, Certified Nurse Midwife, Breastfeeding/Lactation Educator, Physician Assistant (PA), or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, Optometrist, Optician, Registered Dietitian, or Certified Diabetes Educator, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered and acts within the scope of his or her license and/or scope of practice. See also the Definition of Physician. Some of the terms used in this Definition are also defined separately in this Article, such as Physician Assistant.

89. **Health Care Provider:** A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility/Long Term Acute Care facility, as those terms are defined in this Definitions Article.

90. **Health Factor:** The term, as defined under the HIPAA Interim Final Rules for Nondiscrimination in Health Coverage in the Group Market, effective March 9, 2001, as amended, means any of the following eight (8) health related factors: health status, medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability.

91. **Home Health Care:** Intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency as those terms are defined in this Article.

92. **Home Health Care Agency:** An agency or organization that provides a program of home health care and meets one of the following three tests:
    (a) It is approved by Medicare and/or accredited by The Joint Commission (TJC); or
    (b) It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
    (c) If licensing is not required, it meets all of the following requirements:
        1) has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home.
        2) has a full-time administrator.
        3) is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs).
        4) maintains written clinical records of services provided to all patients.
        5) its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
        6) its employees are bonded.
        7) maintains malpractice insurance coverage.

93. **Homeopathy:** A school of medicine based on the theory that when large doses of drugs or substances will produce symptoms of an Illness in healthy people, administration of very small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar."

94. **Hospice:** An agency or organization that administers a program of palliative care and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. "Palliative care" refers to care of a patient whose disease is not responsive to curative treatment and includes control of pain and other symptoms along with psychological, social and spiritual support. Many hospice organizations are members of the National Hospice and Palliative Care Organization (NHPCO). The hospice agency must meet one of the following tests:
    (a) It is approved by Medicare; or is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
    (b) If licensing is not required, it meets all of the following requirements:
        1) provides 24 hour-a-day, 7 day-a-week service.
        2) is under the direct supervision of a duly qualified Physician.
        3) has a full-time administrator.
        4) has a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
        5) the main purpose of the agency is to provide Hospice services.
        6) maintains written records of services provided to the patient.

7) maintains malpractice insurance coverage.

A Hospice that is part of a Hospital, as defined in this Article, will be considered a Hospice for the purposes of this Plan.

95. **Hospital:** means a class of health care institutions that is a public or private facility or institution, licensed and operating as a hospital in accordance with the laws of the appropriate legally authorized agency, which:

(a) provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises; and

(b) provides diagnosis and treatment on an inpatient basis for compensation; and

(c) is approved by Medicare as a Hospital.

The facility may also be accredited as a hospital by The Joint Commission (TJC). A hospital may include facilities for Behavioral Health treatment that are licensed and operated according to law.

Any portion of a Hospital used as an Ambulatory Surgical/Outpatient Surgery Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Inpatient Rehabilitation facility, Subacute Care Facility/Long Term Acute Care facility or other residential treatment facility or place for rest, Custodial Care, or facility for the aged will **not** be regarded as a Hospital for any purpose related to this Plan..

96. **Illness:** Any bodily sickness or disease, including any congenital abnormality of a newborn Child, as diagnosed by a Physician and as compared to the person's previous condition. However, **infertility is not an Illness** for the purpose of coverage under this Plan. **The Plan does not pay for expenses related to the maternity care and delivery expenses associated with a pregnant Dependent Child.** This exclusion of maternity care for a pregnant Dependent Child **does not apply to the extent the expenses qualify as prenatal and postnatal office visits, or preventive services consistent with Health Reform,** but the exclusion does apply to maternity services that are not office visits such as ultrasounds and delivery expenses.

Independent Freestanding Emergency Department: A health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

97. **Infusion Therapy:** Infusion therapy involves the administration of medication or nutrition through a needle or catheter. It is prescribed when a patient's condition is so severe that the condition cannot be treated effectively by oral medications or other nutrition routes. Commonly administered infusion therapy includes infusion of antibiotic, antifungal, antiviral, chemotherapy, hydration, pain management, parenteral nutrition, and total parenteral nutrition or TPN. Diseases commonly requiring infusion therapy include infections that are unresponsive to oral/intramuscular antibiotics, cancer and cancer-related pain, dehydration, gastrointestinal diseases or disorders which prevent normal functioning of the gastrointestinal system, etc.

98. **Inherited Metabolic Disorder**: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, tissue or enzyme analysis. Inherited metabolic disorders are also referred to an inborn error of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia and diabetes are not inherited metabolic disorders under this Plan. See also Medical Foods.

99. **Injury:** Any damage to a body part resulting from trauma from an external source.

100. **Injury to Teeth:** An injury to the teeth caused by trauma from an external source. This **does not include** an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for Accidental Injury to Teeth may be payable under Oral services in the Schedule of Medical PPO Plan Benefits.

101. **In-Network Services:** Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organizations (PPO) as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is **not** a member of the PPO.

102. **Inpatient Services:** Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board.

103. **Investigational:** See the Definition of Experimental and/or Investigational.

104. **Long Term Acute Care (LTAC) Facility:** See the Definition of Subacute Care Facility.

105. **Maintenance Care:** Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

106. **Managed Care:** Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

107. **Massage**: See Therapeutic Massage.

108. **Maximum Plan Benefits:** The maximum amount of Benefits payable by the Plan (and described more fully in the Medical PPO Plan Benefits and Dental PPO Plan Benefits Articles of this document) on account of medical or dental expenses incurred by any covered Plan Participant. There are two general types of plan maximums, described below:
    (a) **Limited Overall Maximum Plan Benefits** are the maximum amount of Benefits payable on account of certain covered medical and/or dental services or supplies by the Plan during the entire time a Plan Participant is covered under this Plan and any previous medical and/or dental expense plan provided by the Fund. The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the limits of those Benefits are identified in the Schedule of Medical PPO Plan Benefits and Schedule of Dental PPO Plan Benefits.
    (b) **Annual Maximum Plan Benefits** are the maximum amount of Benefits payable each Calendar Year on account of certain medical and/or dental expenses incurred by any covered Plan Participant or family of the Plan Participant under this Plan. Annual Maximums are identified in the Schedule of Medical PPO Plan Benefits.

109. **Medical Foods:** Modified low protein foods and metabolic formulas as described here:
    (a) Modified Low Protein foods are foods that are formulated to be consumed or administered through the gastrointestinal tract and are processed or formulated to contain less than one gram of protein per unit of serving and are administered for the medical and nutritional management of a person who has limited ability to properly metabolize food or nutrients and such medical food is essential to the person's growth, health and metabolic homeostasis and are administered under the direction of a Physician for a person who has an inherited metabolic disorder.
    (b) Metabolic Formulas are solutions consumed or administered through the gastrointestinal tract and are processed or formulated to be deficient in one or more nutrients present in typical food products and are administered because a person has limited ability to properly metabolize food or nutrients and such medical food is essential to the person's growth, health and metabolic homeostasis and are administered under the direction of a Physician for a person who has an inherited metabolic disorder. See the Definition of inherited metabolic disorder. Certain Enteral Therapy is payable as noted in the Schedule of Medical PPO Plan Benefits.
    (c) Medical Foods are NOT natural foods low in protein and/or galactose, gluten, carbohydrates, fats, spices, flavorings, or foods or formulas required by persons who do not have inherited metabolic disorders as that term is defined in this document.

110. **Medically Necessary/Medical Necessity**:
    (a) A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Board of Trustees or its designee if it:
        1) is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and
        2) is determined by the Board of Trustees or its designee to be necessary in terms of generally accepted American medical and dental standards; and
        3) is determined by the Board of Trustees or its designee to meet all of the following requirements:
            - It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
            - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; and
            - It is an **"Appropriate"** service or supply given the patient's circumstances and condition; and
            - It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; and
            - It is safe and effective for the illness or injury for which it is used.
    (b) A medical or dental service or supply will be considered to be **"Appropriate"** if:
        1) It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
        2) It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
    (c) A medical or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.
    (d) The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.
    (e) A Hospitalization or confinement to a Health Care Facility will not be considered to be Medically Necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

(f) A medical or dental service or supply that can safely and appropriately be furnished in a Physician's or Dentist's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

(g) The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.

(h) A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Practitioner, Hospital or Health Care Facility.

111. **Medicare:** The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

112. **Mental Health; Mental Disorder; Mental and Nervous Disorder:** See the Definition of Behavioral Health Disorder.

113. **Midwife: See Nurse Midwife.**

114. **Nurse Midwife, Certified Nurse Midwife:** A person legally licensed as a midwife or certified as a certified nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license. A Midwife may **not** independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the Definition of Nurse. Expenses associated with a pre-planned home birth are not payable by this Plan.

115. **Naprapathy**: A system of treatment by manipulation of connective tissue and adjoining structures and by dietary measures that is held to facilitate the recuperative and regenerative processes of the body. When the services of a Naprapath are payable by this Plan, the Naprapath must be properly licensed to practice Naprapathy in the state in which he or she is practicing and must be performing services within the scope of that license.

116. **Naturopathy:** A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage or herbal tea.

117. **Near-site clinic:** A local physical clinic owned and managed by an independent clinic administrator under contract to the Fund. The clinic is staffed with physicians, advanced practitioners, and medical assistants to provide a variety of health care services including primary care, urgent care, preventive care, chronic condition management, and certain outpatient prescription drugs.

118. **Nondurable Supplies:** Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, single use vials, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the Definitions of Corrective Appliances, Durable Medical Equipment, Orthotic appliance (or Device) and Prosthetic appliance (or Device). Only those nondurable supplies identified in the Schedule of Medical PPO Plan Benefits are covered by this Plan. All others are not.

119. **Non-Network:** See Out-of-Network.

120. **Non-Participating Provider:** A Health Care Provider who **does not participate** in the Plan's Preferred Provider Organizations (PPO). Also referred to as Non-PPO, Out-of-Network or Non-Network.

121. **Nurse:** A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

122. **Nurse Anesthetist:** A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA), and authorized to administer anesthesia in collaboration with a Physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

123. **Nurse Practitioner:** A person legally licensed as a Nurse Practitioner (NP), Family Nurse Practitioner (FNP) or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate

Health Care Practitioners and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered.

124. **Occupational Therapist:** A person legally licensed as a professional occupational therapist who acts within the scope of their license, and acts under the direction of a Physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living (such as eating, bathing, dressing) and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence. Other occupational therapy services can include assessment of perceptual motor and sensory activity, the design, fabrication or application of selected support devices (orthotics) such as a wrist brace or ankle support, training on how to utilize prosthetic devices to maximize independence, guidance in the selection and use of adaptive equipment, teaching exercises to enhance functional performance and adaptation of environments for people with mental and physical disabilities.

125. **Off-Label:** Off-label prescription drugs are FDA-approved prescription drugs that are prescribed for indications other than those stated in the labeling approved by the FDA.

126. **Office Visit:** A direct personal contact between a Physician or other Health Care Practitioner and a patient in the Health Care Practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT or CDT coding. The following are not considered to be an office visit: a visit to a Health Care Practitioner's office where no office visit code is billed or a visit to a Health Care Practitioner's office for blood drawing, leaving a specimen, or receiving a routine injection.

127. **Ophthalmologist** is a Physician (MD or DO) licensed to practice ophthalmology, including eye surgery and prescription of drugs.

128. **Optician** means a person qualified to manufacture and dispense eyeglasses and/or contact lenses.

129. **Optometrist** is a person licensed to practice optometry.

130. **Orthognathic Services:** Services dealing with the cause and treatment of malposition of the bones of the jaw, such as to shorten or lengthen the horizontal, vertical or transverse dimensions of the jaw so that facial soft tissue, teeth and/or other facial structures are in aesthetic alignment/balance. Malposition can produce conditions such as Prognathism, Retrognathism, or Temporomandibular Joint syndrome/dysfunction. See the Definitions of Prognathism, Retrognathism, and Temporomandibular Joint syndrome/dysfunction.

131. **Orthotic (Appliance or Device):** A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this Definition does **not** include Dental Orthotics. See also the Definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic appliance (or Device).

132. **Out-of-Network Services (Non-Network):** Services provided by a Health Care Provider that is **not** a member of the Plan's Preferred Provider Organizations (PPO), as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO.

133. **Out-of-Pocket Limit**: See the Out-of-Pocket Limit row in the Schedule of Medical PPO Plan Benefits.

134. **Outpatient Services:** Services provided either outside of a hospital or Health Care Facility setting or at a hospital or Health Care Facility when room and board charges are **not** incurred.

135. **Partial Hospitalization**: means treatment of mental, nervous, or emotional disorders and substance use for at least three (3) hours, but not more than twelve (12) hours in a twenty-four (24) hour period.

136. **Participating Provider:** A Health Care Provider who participates in the Plan's Preferred Provider Organizations (PPO).

137. **Participant**: see the Definition of Covered Individual.

138. **Pharmacist:** A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

139. **Physical Therapist:** A person legally licensed as a professional physical therapist who acts within the scope of their license, and acts under the direction of a Physician to perform physical therapy services including the evaluation, treatment and education of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical functional disability/impairment. Physical therapists may also perform testing and retraining of muscle strength, joint motion, or sensory and neurological function along with balance, coordination, and flexibility in order to enhance mobility and independence.

140. **Physical Therapy:** Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform certain activities of daily living such as walking and getting in and out of bed.

141. **Physician:** A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) or Doctor of Podiatric Medicine (DPM) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license. See also the Definition of Health Care Practitioner.

142. **Physician Assistant (PA):** A person legally licensed as a Physician Assistant, who acts within the scope of his or her license and acts under the supervision of a Physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising Physician; and bill and be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered.

143. **Placed for Adoption:** For the Definition of Placed for Adoption as it relates to coverage of adopted Dependent Children, see the Definition in the section on Adopted Dependent Children in the Eligibility Article.

144. **Plan, This Plan:** The programs, Benefits and provisions described in this document.

145. **Plan Assets**. All funds, payment, contributions and monies owed to the Plan, whether or not paid and received.

146. **Plan Administrator:** The Board of Trustees of Teamsters Security Fund for Southern Nevada - Local 14 has been designated as the Plan Administrator and has the responsibility for overall Plan administration. The Board of Trustees may designate various third parties as claims administrators for various benefits of the Plan. See also the Definition of Claims Administrator.

147. **Plan Participant:** See the Definition of Covered Individual.

148. **Plan Sponsor**: The Board of Trustees of the Teamsters Security Fund for Southern Nevada – Local 14 and sponsoring Union and Employers.

149. **Plan Year:** The twelve-month period from January 1 to December 31 is designated to be the Plan Year. See also the definition of Calendar Year.

150. **Podiatrist:** A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

151. **Post-service Claim:** See the Claim Filing and Appeal Information Article for the Definition.

152. **PPO:** see Preferred Provider Organization.

153. **Pre-Admission Testing:** Laboratory tests and x-rays and other Medically Necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery.

154. **Precertification:** Precertification is a review procedure performed by the Utilization Review and Case Management Company, Prescription Drug Program or Administrative Office (depending on the type of service being precertified) **before** services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service, admission and/or length of stay in a health care facility is appropriate and Medically Necessary. Precertification is also referred to as pre-service review, prior authorization, precert, prior auth or preapproval. See also the Utilization Review and Case Management Article of this document.

155. **Preferred Provider Organization (PPO):** An independent group or network of Health Care Providers (*e.g.* hospitals, Physicians, laboratories) under contract with an organization, which has a contract with the Plan, to provide health care services and supplies at agreed-upon discounted/reduced/negotiated rates.

156. **Prescription Drugs:** For the purposes of this Plan, Prescription Drugs include:
    (a) **Federal Legend Drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
    (b) **Compound Drug:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law. Some compound drugs are only available at a retail pharmacy location, not mail order.
    (c) **Brand drug:** means a drug that has been approved by the FDA and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.

(d) **Generic drug**: means a generic version of a brand-name drug (basically a copy of an FDA approved brand-name drug that contains the same active ingredients as the brand-name drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance and intended use). Generic drugs work in the same way and in the same amount of time as brand-name drugs. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the FDA. Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.

(e) **Specialty drug**: Generally refers to high-cost, low volume, biotechnology-engineered FDA approved, non-experimental medications used to treat complex, chronic or rare diseases. These medications may also have one or more of the following qualities: are injected, infused, taken oral or inhaled, may need to be administered by a Health Care Practitioner, have side-effects or compliance issues that need monitoring, require substantial patient education/support before administration, and/or have unique manufacturing, handling and distribution issues that make them unable to be purchased from a retail and/or mail order service. Examples of specialty drugs can include medications to treat hemophilia, immunity disorders, multiple sclerosis, rheumatoid arthritis, hepatitis or certain types of cancer. Specialty drugs are managed by a specialty drug pharmacy which is part of the Prescription Drug Program under contract to the Plan. See the Drug row of the Schedule of Medical PPO Plan Benefits for more information.

157. **Pre-service Claim:** See the Claim Filing and Appeal Information Article for the Definition.

158. **Preventive services/Preventive Care Benefits:** are defined under the Patient Protection and Affordable Care Act (Health Care Reform) and include recommended services rated as "A" or "B" by the U.S. Preventive Services Task Force (USPSTF) with respect to the individual involved, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive care and screenings for women and Children as recommended by the Health Resources and Services Administration (HRSA).

159. **Primary Care Provider (PCP)** means a Physician (MD or DO) or other Health Care Practitioner who practices general practice, family practice, internal medicine, pediatrics or obstetrics/gynecology (OB/GYN). All other Physicians are considered specialists under this Plan. Under this Medical PPO Plan, there is no requirement to select a primary care provider (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider.

160. **Prior Authorization/Prior Approval:** See Precertification.

161. **Prognathism:** The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face. See also Orthognathic.

162. **Prosthetic Appliance (or Device):** A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the Definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

163. **Provider:** See the Definition of Health Care Provider.

164. **Pulmonary Rehabilitation**: Pulmonary Rehabilitation refers to a formal program of controlled exercise training and respiratory education under the supervision of qualified medical personnel capable of treating respiratory emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to their highest functional level of activity/endurance, decrease respiratory symptoms/complications, and encourage self-management and control over their chronic lung problems. Patients are to continue at home, the exercise and educational techniques they learn in this program. Pulmonary rehabilitation services are payable for patients who have a chronic respiratory disorder such as chronic obstruction pulmonary disease (COPD), emphysema, pulmonary fibrosis, asthma, etc.

165. **Qualified Medical Child Support Order (QMCSO):** A court order that complies with requirements of federal law requiring an Employee to provide health care coverage for a Dependent Child, and requiring that Benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child. See also the Eligibility Article of this document.

166. **Reconstructive Surgery:** A Medically Necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

167. **Rehabilitation Therapy:** Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or

her license. Rehabilitation does not have the same meaning as Habilitation. Rehabilitation focuses on restoring/regaining functions that have been lost due to injury or illness, while Habilitation focuses on helping individual attain certain functions that they never have acquired. See also the Definition of Habilitation.

See the Schedule of Medical PPO Plan Benefits and the Medical PPO Plan Exclusions Article of this document to determine the extent to which Rehabilitation Therapies are covered. See also the Definition of Physical Therapy, Occupational Therapy, Speech Therapy, Habilitation, Pulmonary Rehabilitation and Cardiac Rehabilitation.

(a) **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

(b) **Acute Rehabilitation** means intensive efforts involving physical, speech and occupational therapies and reeducation to help a patient regain mobility, strength and flexibility following a severe injury, debilitating disease or following certain types of surgery. Acute Rehabilitation care may be administered in a designated part of a hospital or at a free-standing rehabilitation facility.

(c) **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**

(d) **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be Medically Necessary for the purposes of this Plan.**

168. **Relative:** means the patient's:

(a) Spouse, father, mother, brother, sister, son, daughter or grandchildren; or

(b) any other relative residing at the same address as the patient.

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

170. **Residential Treatment/Care:** is defined as a 24-hour level of care for people with long-term or severe mental (psychiatric) disorders or with substance-related (alcohol/drug) disorders. Such treatment/care settings are licensed at the residential intermediate level or as an intermediate care facility (ICF). Licensure requirements for this level of care may vary by state. Residential care is medically monitored, with 24-hour medical and nursing services availability and less intensive medical monitoring than subacute or acute hospital care.

171. **Retiree**: Eligibility for Retirees is addressed in Article III. Only early Retirees (Non-Medicare Retirees) are permitted to enroll in this Plan, not Medicare-eligible Retirees.

172. **Retrognathism:** The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face. See also Orthognathic.

173. **Retrospective Review:** Review of health care services **after** they have been provided to determine if those services were Medically Necessary and/or if the charges for them are an Allowable Expense.

174. **Second Opinion:** A consultation and/or examination, preferably by a board certified Physician not affiliated with the primary attending Physician, to evaluate the Medical Necessity and advisability of undergoing surgery or receiving a medical service.

175. **Service Area:** The geographic area serviced by the In-Network Health Care Providers who have agreements with the Plan's PPOs. See the Medical Networks Article for additional information.

176. **Skilled Nursing Care:** Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of Skilled Nursing Care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

177. **Skilled Nursing Facility (SNF):** A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets **all** of the following requirements:
    (a) It is accredited by The Joint Commission (TJC) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
    (b) It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
    (c) It provides services under the supervision of Physicians; and
    (d) It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and
    (e) It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
    (f) It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled/custodial) care, assisted living, memory care/dementia care facility, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill; and
    (g) It is not a hotel or motel.

    A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

178. **Specialty Care Unit:** A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

179. **Specialty Care Hospital/Facility**: See the Definition of Subacute Care Facility.

180. **Speech Therapist**: A person legally licensed as a professional speech therapist who acts within the scope of their license, and acts under the direction of a Physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

181. **Speech Therapy**: Rehabilitation directed at treating defects and disorders of spoken and written communication to **restore or rehabilitate** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure. Speech therapy for functional purposes, including but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin or Childhood developmental speech delays/disorders that have not been surgically corrected are excluded from coverage.

182. **Spinal Manipulation:** The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors, but it can be performed by Physicians.

183. **Spouse:** A Retiree's Spouse means a legal Spouse including a same gender Spouse. The Plan will require proof of the legal marital relationship. The following are not defined as a Spouse under this Plan: a legally separated Spouse, a Domestic Partner, a civil union, or a divorced former Spouse of a Retiree, a common law marriage, or a Spouse of a Dependent Child.

184. **Subacute Care Facility:** A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility or as a stand-alone facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** of the following requirements:
    (a) It is accredited by The Joint Commission (TJC) as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; and
    (b) It maintains on its premises all facilities necessary for medical care and treatment; and
    (c) It provides services under the supervision of Physicians; and
    (d) It provides nursing services by or under the supervision of a licensed Registered Nurse; and
    (e) It is not (other than incidentally) a place for rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or diagnosed with tuberculosis; and
    (f) It is not a hotel or motel.

    Subacute care facility is sometimes referred to as a specialty hospital or post acute care, or long term acute care (LTAC) facility. Long term acute care means treatment for patients with medically complex conditions that require intensive, special treatment for an extended stay in a health care facility.

185. **Subrogation:** This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Recovery Rules in the Coordination of Benefits Article for an explanation of how the Plan may use the right of subrogation to be substituted in place of a Covered Individual in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical and/or dental Benefits paid if the Covered Individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit. Plan Assets include all contributions and payments owed to the Plan from the accrual date, whether or not paid. Employees, Retirees, Dependents and legal representatives are required to sign approved Benefit reimbursement agreements.

186. **Substance Use Disorder:** A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the Definitions of Behavioral Health Disorders and Chemical Dependency.

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

(a) Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of the Allowable Expense
Secondary and additional procedures	50% of the Allowable Expense per procedure

(b) Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of the Allowable Expense
First site secondary and additional procedures	50% of the Allowable Expense per procedure
Second site primary and additional procedures	50% of the Allowable Expense per procedure

188. **Surgical Assistant:** See Certified Surgical Assistant.

189. **Surgical Center:** see Ambulatory Surgical Facility/Center.

190. **Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome:** The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking), myofacial pain (pain in the muscles of the face), headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

191. **Terminally Ill:** means a medical prognosis of six months or less to live, as diagnosed by a Physician.

192. **Therapist:** A person trained and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy who is legally licensed to perform such services (where licensing required by State law) and who works within the scope of his or her license and provides services under the direction of a Physician, is allowed to bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered. For further information, see the Definition of Occupational, Physical and Speech Therapy.

193. **Therapeutic Massage**: The terms massage, therapeutic massage and massage therapy refer to the use of structured palpation or movement of the soft tissues of the body to enhance the muscle and skin tone, flexibility/mobility, circulation, and general health/well-being of the patient. Massage services include, but are not limited to, such techniques as effleurage (stroking the skin), gliding, friction, vibration, compression, passive or active stretching within the normal anatomical range of movement; petrissage (kneading, lifting or picking up muscles and rolling the folds of skin) and tapotement (percussion and rhythmic movements of the hand). Under this Plan therapeutic massage is payable only when such services are billed using appropriate CPT coding and performed by a Health Care Practitioner that is licensed to perform therapeutic massage or, where licensing is not required, who is certified by the National Certification Board for Therapeutic Massage and Bodywork (NCBTMB). Therapeutic massage does not include the diagnosis of a specific pathology, the prescription of drugs or controlled substances, spinal manipulation, aromatherapy (use of aromatic oils), acupuncture/acupressure, body wraps/masks, facials/peels, etc. or those acts of physical therapy that are outside the scope of massage therapy.

194. **Third Opinion:** A consultation and/or examination, preferably by a board certified Physician not affiliated with the primary attending Physician, to evaluate the Medical Necessity and advisability of undergoing Surgery or receiving a medical service, provided by the Plan when the Second Opinion indicates that the recommended Surgery or medical service is not Medically Necessary.

195. **Totally Disabled:** The inability of a covered Employee to perform all the duties of his or her occupation with an employer as a result of a non-occupational illness or injury, or the inability of a covered Dependent to perform the normal activities or duties of a person of the same age and sex. See also the Definition of Disabled.

196. **Transplant, Transplantation:** The transfer of whole or partial organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, peripheral stem cells, cornea, skin, tendon or bone) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.
    (a) **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow, peripheral stem cells and skin transplants are often autologous.
    (b) **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are allogenic.
    (c) **Xenographic/xenotransplant** refers to transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the transplant of an organ from an animal to a human). Expenses related to xenographic services are **not** covered by this Plan, except as determined to be an FDA-approved use of xenographic tissue such as a porcine heart valve.

    See the Schedule of Medical PPO Plan Benefits and the Medical PPO Plan Exclusions Article for additional information regarding Transplants. See also the Utilization Review and Case Management Article of this document for information about precertification requirements for transplantation services.

197. **Trust Agreement:** means the Trust Agreement establishing the Teamsters Security Fund for Southern Nevada - Local 14, and any restatement, modifications, amendment, extension or renewal thereof.

198. **Union or Local Union:** means Teamsters Local 14.

199. **Urgent Care:** Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is **not** in jeopardy. Examples of medical conditions that may be appropriate for Urgent Care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

200. **Urgent Care Claim:** See the Claim Filing and Appeal Information Article for the Definition.

201. **Urgent Care Facility:** A public or private Hospital-based or free-standing facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

202. **Utilization Review and Case Management (UR/CM):** A managed care procedure to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to Precertification and/or preauthorization; Concurrent and/or continued stay review; Discharge planning; Retrospective review; Case Management; Hospital or other Health Care Provider bill audits; and Health Care Provider fee negotiation. Utilization Review and Case Management services (sometimes referred to as Utilization Management, UM services, UM program, or UMR services) are provided by licensed health care professionals employed by the Utilization Review and Case Management Company operating under a contract with the Plan.

203. **Utilization Review and Case Management Company:** The independent Utilization Review and Case Management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan's Utilization Review and Case Management services.

204. **Visit:** See the Definition of Office Visit.

205. **Well Baby Care; Well Child Care:** Health care services provided to a healthy newborn or Child that are determined by the Plan to be Medically Necessary even though they are not provided as a result of illness, injury or congenital defect. The Plan's coverage of Well Child Care is described under Wellness/Preventive Care in the Schedule of Medical PPO Plan Benefits.

206. **You, Your:** When used in this document, these words refer to the Retiree who is covered by the Plan. They do **not** refer to any Dependent of the Non-Medicare Retiree.