

**BRICKLAYERS AND ALLIED CRAFTWORKERS
LOCAL 1 OF PA/DE HEALTH & WELFARE FUND**

Summary Plan Description and
Plan Document

As Amended and Restated Effective May 1, 2019

**BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 1
OF PA/DE HEALTH & WELFARE FUND
SUMMARY PLAN DESCRIPTION AND PLAN OF BENEFITS**

May 1, 2019

To All Participants:

We are pleased to provide you with this updated Summary Plan Description and Plan of Benefits (“SPD” or “Plan”). Unless expressly stated otherwise, this SPD is effective May 1, 2019. You’ve received this SPD based on your work in employment covered by the Bricklayers and Allied Craftworkers Local 1 of PA/DE Health & Welfare Fund. However, you must satisfy the eligibility requirements shown on the following pages in order to qualify for benefits. Since the purpose of the Bricklayers and Allied Craftworkers Local 1 of PA/DE Health & Welfare Fund is to benefit you and your family, we urge you to read this SPD carefully so that you will understand the complete Plan of Benefits, as well as the eligibility rules and procedures for filing claims.

We strive to offer a Plan of Benefits that makes meaningful contributions to your security, health and well-being. Nevertheless, changing economic conditions require a constant assessment of the Plan to maintain the Fund’s financial stability. Within this framework, we will continue to monitor the Fund’s resources in an effort to ensure that it will provide high-quality health coverage to members and their families for years to come.

Very truly yours,

*The Board of Trustees of the Bricklayers and Allied
Craftworkers Local 1 of PA/DE Health & Welfare Fund*

IMPORTANT

The Board of Trustees, in its sole discretion, may interpret, amend, or terminate the Plan and any of its provisions, in whole or in part, at any time. This means that: (1) the Board of Trustees has the exclusive discretionary authority to determine all questions regarding coverage, eligibility, entitlement to benefits and other related matters; (2) all Plan benefits made available to Participants are conditional and subject to the Board of Trustees’ exclusive discretionary authority to improve, reduce, eliminate or otherwise modify them; and (3) the Board of Trustees has the exclusive discretionary authority to modify or terminate the Plan’s provisions related to classes of coverage, eligibility, the availability, nature and extent of benefits, and the conditions, methods and rates of payment and self-payment.

Interpretations regarding eligibility for benefits, claims, status of Covered Persons or Employers, or any other matter relating to the Plan should only be obtained through the full Board of Trustees. The Trustees are not bound by, responsible for, or obligated by opinions, information, or representations from any other source.

All the provisions of this booklet are very important and we encourage you to read them carefully. For additional information and assistance, feel free to contact the Fund’s Administrator:

Maria Morris
2704 Black Lake Place
Philadelphia, PA 19154
P: (215) 856-9663

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OF PA/DE HEALTH & WELFARE FUND
SUMMARY PLAN DESCRIPTION AND PLAN OF BENEFITS**

TABLE OF CONTENTS

CHAPTER	1	–
DEFINITIONS	1	
Section 1.01 – General Definitions		1
CHAPTER	2	–
ELIGIBILITY	3	
Section 2.01 – Initial Eligibility for Employees		3
Section 2.02 – Continuing Eligibility for Employees		3
Section 2.03 – Eligibility for Dependents		5
Section 2.04 – Eligibility for Retirees		7
Section 2.05 – Termination of Eligibility		7
Section 2.06 – Reinstatement of Coverage		8
Section 2.07 – Eligibility During / After Periods of Military Service		9
Section 2.08 – Eligibility During FMLA Leave		10
CHAPTER	3	–
COVERAGE	12	
Section 3.01 – COBRA Continuation Coverage		12
Section 3.02 – COBRA Rules for Employees		12
Section 3.03 – COBRA Rules for Dependents		12
Section 3.04 – Notice Requirements for COBRA Continuation Coverage		13
Section 3.05 – Election of COBRA Continuation Coverage		13
Section 3.06 – Required Premiums		14
Section 3.07 – Termination of COBRA Continuation Coverage		14
CHAPTER	4	–
BENEFITS	15	
PART A – GENERAL INFORMATION REGARDING YOUR MEDICAL BENEFITS		15
Section 4.01 – Independence Blue Cross / Personal Choice Network		15
Section 4.02 – Allied Trades Assistance Program (ATAP)		16
Section 4.03 – In-Network / Out-of-Network		16
Section 4.04 – Deductibles / Maximums / Coinsurance / Copayments		17
Section 4.05 – Schedule of Benefits		18
PART B – DETAILED INFORMATION REGARDING SPECIFIC COVERED BENEFITS		21
Section 4.06 – Alcohol or Drug Abuse and Dependency		21
Section 4.07 – Ambulance Services		22
Section 4.08 – Autism Spectrum Disorders		23
Section 4.09 – Blood		24
Section 4.10 – Colorectal Cancer Screening		24

Section 4.11 – Day Rehabilitation Program	25
Section 4.12 – Diabetic Education Program, Equipment & Supplies	25
Section 4.13 – Diagnostic Services	26
Section 4.14 – Durable Medical Equipment	26
Section 4.15 – Emergency Care Services	28
Section 4.16 – Home Health Care	28
Section 4.17 – Hospice Services	29
Section 4.18 – Hospital Services	30
Section 4.19 – Immunizations	31
Section 4.20 – Injectable Medications / Specialty Drugs	31
Section 4.21 – Insulin and Oral Agents	32
Section 4.22 – Maternity / OBGYN / Family Services	32
Section 4.23 – Medical Care	32
Section 4.24 – Medical Foods and Nutritional Formulas	33
Section 4.25 – Mental Health / Psychiatric Care	33
Section 4.26 – Non-Surgical Dental Services	34
Section 4.27 – Nutrition Counseling for Weight Management	35
Section 4.28 – Orthotics	35
Section 4.29 – Podiatric Care	35
Section 4.30 – Preventive Care	35
Section 4.31 – Primary Care Physician Office & Retail Clinic Visits	38
Section 4.32 – Private Duty Nursing Services	38
Section 4.33 – Prosthetic Devices	38
Section 4.34 – Skilled Nursing Facility Services	39
Section 4.35 – Specialist Office Visits	40
Section 4.36 – Spinal Manipulation Services	40
Section 4.37 – Surgical Services	40
Section 4.38 – Therapy Services	42
Section 4.39 – Transplant Services	44
Section 4.40 – Urgent Care Centers	45
PART C – COST-MANAGEMENT RULES AND PROCESSES	45
Section 4.41 – Preapproval / Precertification	45
Section 4.42 – Utilization Review Process	46
PART D – DEFINITIONS	46
Section 4.43 – Definitions	46
Section 4.44 – Types of Providers	51
CHAPTER 5	–
EXCLUSIONS 55	
Section 5.01 – In General	55
Section 5.02 – General Exclusions	55
Section 5.03 – Specific Exclusions	59
CHAPTER 6	–
BENEFITS 62	
Section 6.01 – Prescription Drug Program	62
Section 6.02 – Pharmaceutical Benefit Manager	62

CHAPTER	7	–	DENTAL,	VISION	&	VACATION	
BENEFITS	64						
	Section 7.01 – Dental Benefits						64
	Section 7.02 – Vision Benefits						64
	Section 7.03 – Vacation Benefits						65
CHAPTER	8	–	DEATH	/	ACCIDENTAL	DEATH	&
DISMEMBERMENT	67						
	Section 8.01 – In General						67
	Section 8.02 – Schedule of Death / Accidental Death & Dismemberment Benefits						67
	Section 8.03 – Designated Beneficiary						68
	Section 8.04 – Conflict						68
CHAPTER	9	–		COORDINATION			OF
BENEFITS	69						
	Section 9.01 – Coordination of Benefits In General						69
	Section 9.02 – How Benefits Are Coordinated						69
	Section 9.03 – Right to Information						70
	Section 9.04 – Right to Correct Erroneous Payments						70
CHAPTER	10	–		REIMBURSEMENT			&
SUBROGATION	71						
	Section 10.01 – Right to Recovery Payments						71
	Section 10.02 – Reimbursement of Conditional Benefit Payments						71
	Section 10.03 – Subrogation						74
CHAPTER 11 – CLAIMS AND APPEALS PROCEDURES							75
	Section 11.01 – In General						75
	Section 11.02 – Where to File						75
	Section 11.03 – Right to an Authorized Representative						76
	Section 11.04 – Applicable Definitions						76
	Section 11.05 – Timeframes for Making Initial Claim Decisions						77
	Section 11.06 – Content of Initial Denial Notices						79
	Section 11.07 – Your Right to Appeal						80
	Section 11.08 – Timing of Notification of Decision on Appeal						81
	Section 11.09 – Content of Notice of Decision on Appeal						82
	Section 11.10 – Special Rules for Disability Determinations						82
	Section 11.11 – Decision on Appeal						84
	Section 11.12 – Policies, Determinations or Actions						84
CHAPTER	12	–		IMPORTANT		MISCELLANEOUS	
PROVISIONS	86						
	Section 12.01	–	Plan	Interpretation,	Amendment	and	
	Termination						86
	Section 12.02 – No Vesting						86
	Section 12.03 – Exclusive Right to Benefits						86
	Section 12.04 – No Assignment or Attachment of Benefits						87
	Section 12.05 – No Liability for Practice of Medicine						87
	Section 12.06 – Workers’ Compensation						87

Section 12.07 – Allocating / Delegating Trustee Authority; Actions in Accordance With Trust.....	87
Section 12.08 – Preservation of Plan Provisions	88
Section 12.09 – Governing Law and Forum Selection Clause	88

CHAPTER 13 – GENERAL INFORMATION AND YOUR ERISA RIGHTS 89

Section 13.01 – Name of the Plan	89
Section 13.02 – Plan Administration	89
Section 13.03 – Name of Plan Sponsor	90
Section 13.04 – Agent for Service of Legal Process.....	90
Section 13.05 – Plan Number and Employer Identification Number (EIN)	90
Section 13.06 – Type of Plan	90
Section 13.07 – Plan Year	90
Section 13.08 – Source of Financing.....	90
Section 13.09 – Service Providers	90
Section 13.10 – Compliance with Privacy Standards.....	91
Section 13.11 – Your Rights Under ERISA.....	91
Section 13.12 – Women’s Health and Cancer Rights Act of 1998.....	93
Section 13.13 – Grandfathered Plan Disclosure.....	93

CHAPTER 1—DEFINITIONS

The following terms have special meanings when used in this SPD.

1.01 GENERAL DEFINITIONS

(a) Agreement and Declaration of Trust / Trust Agreement

Agreement and Declaration of Trust means the Bricklayers and Allied Craftworkers Local 1 of PA/DE Health & Welfare Fund Agreement and Declaration of Trust, as amended from time to time.

(b) Collective Bargaining Agreement

Collective Bargaining Agreement means an Agreement between the Union and an Employer which provides for contributions to the Fund. An “Agreement” may be a Collective Bargaining Agreement or a Participation Agreement. A “Participation Agreement” is an Agreement between an employer, including but not limited to the Union or an affiliated trust fund, and the Trustees which provides for contributions to the Fund.

(c) Board of Trustees or Trustees

Board of Trustees or Trustees means the Joint Board of Trustees of the Bricklayers and Allied Craftworkers Local 1 of PA/DE Health & Welfare Fund who, in accordance with the Agreement and Declaration of Trust and ERISA, administers the Plan.

(d) COBRA

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which is the federal law mandating the limited availability of continued health care coverage after a qualifying event.

(e) Covered Employment

Covered Employment means work for which an Employer is required to make contributions to the Fund pursuant to a Collective Bargaining Agreement or Participation Agreement.

(f) Covered Person

Covered Person means an Employee, dependent of an Employee, Retiree, or dependent of a Retiree if such person satisfies the applicable eligibility requirements set forth in Chapter 2 of the SPD. The terms Eligible Employee, Eligible Retiree, and Eligible Dependent are used, where appropriate, to describe that category of Covered Person.

(g) Employee

Employee means a person in a job category covered by a Collective Bargaining Agreement or other Agreement on whose behalf an Employer makes, or is obligated to make, contributions to the Fund.

(h) Employer

Employer means an employer who has agreed to make contributions to the Fund in accordance with the terms and conditions of a Collective Bargaining Agreement or other Agreement.

(i) ERISA

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

(j) FMLA

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

(k) Fund

Fund means the Bricklayers and Allied Craftworkers Local 1 of PA/DE Health & Welfare Fund and/or a designated agent of the Fund.

(l) Fund Office

Fund Office means the office of the Plan Administrator, *i.e.*, the Board of Trustees of the Fund. The Trustees have delegated responsibility for the day-to-day administration of the Fund to Maria Morris.

(m) HIPAA

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

(n) Medicare

Medicare means the programs of health care for the aged and disabled as established by title XVIII of the Social Security Act of 1965, as amended.

(o) Plan

Plan means the Bricklayers and Allied Craftworkers Local 1 of PA/DE Health & Welfare Fund Health and Welfare Plan as amended from time to time. This document constitutes the Plan document for purposes of ERISA.

(p) Plan Year

Plan Year means May 1 through April 30. However, for purposes of determining a Covered Person's annual Deductible and all other benefit-related limitations and maximums, the calendar year is used.

(q) PPACA

PPACA means the Patient Protection and Affordable Care Act, Public Law 111-148, enacted March 23, 2010, as amended by the Health Care and Education Reconciliation Act, Public Law 11-152, enacted March 30, 2010.

(r) Union

Union means Bricklayers and Allied Craftworkers Local 1 of PA/DE and its affiliates.

CHAPTER 2—ELIGIBILITY

2.01 INITIAL ELIGIBILITY FOR EMPLOYEES

(a) General Rule

In order to become initially eligible for benefits under the Plan, an Employee must complete 750 hours of Covered Employment within 12 months of the commencement of employment with a participating Employer. Upon completion of 750 hours of Covered Employment within this period, an Employee will become an Eligible Employee on the first day of the second month after the 750 hour minimum is reached.

Example. An Employee is hired in April and reaches 750 hours of Covered Employment in August. The Employee's eligibility would commence effective October 1.

Notwithstanding the foregoing, in the event of substantial and ongoing unemployment in the brick and trowel trades industry, as determined by the Trustees in their sole discretion, the Trustees may suspend the consecutive 12-month limitation period in which the 750 hours of Covered Employment must be accrued provided that such suspension shall be reviewed and re-determined by the Trustees at the second quarterly meeting of the Trustees after the suspension and each extension thereof. A termination of the suspension shall be effective 90 days after the decision of the Trustees.

(b) Eligibility Rules for Employees of Newly Organized Employers

Notwithstanding subsection (a), the Plan may maintain alternative eligibility rules for Employees of newly organized Employers. These rules will be negotiated with the Employer on or about the time at which the Employer becomes signatory to a Collective Bargaining Agreement with the Union and shall be subject to the approval of the Board of Trustees. At that time, you will be notified of the eligibility rules and the coverage that will be provided to you under the Plan.

2.02 CONTINUING ELIGIBILITY FOR EMPLOYEES

(a) General Rule / 100 Hours of Covered Employment Per Month

In order to remain an Eligible Employee, an Employee must complete at least 100 hours of Covered Employment per month. Such hours are credited for continuing eligibility purposes on the first day of the month subsequent to the due date for the contributions associated with such work.

Example. An Employee completes 100 hours of Covered Employment during the month of March. Contributions for hours of Covered Employment completed in March are due no later than April 15. Therefore, the Employee's 100 hours of Covered Employment during the month of March will provide him with continued eligibility for the month of May.

(b) Hour Bank

The Hour Bank is available to continue an Employee's eligibility in situations where the Employee has failed to satisfy the Plan's general continuing eligibility rule.

- (1) *In General.* After satisfying the Plan's initial eligibility rules, an Eligible Employee automatically accumulates 200 hours in the Hour Bank. Thereafter, if the Employee completes more than 100 hours of Covered Employment, the hours in excess of 100 are credited to the Hour Bank up to a maximum of 1,200 hours. During months where the Employee has failed to complete 100 hours of Covered Employment, the Employee's hours in the Hour Bank may be combined with Employer contributions, if any, to meet the monthly minimum to continue coverage.

- (2) *Suspension of Hour Bank.* An Employee's use of the Hour Bank will be suspended if: (A) the Employee is employed by an employer in the brick and trowel trades industry who does not maintain this Plan (i.e., is not signatory to a collective bargaining agreement which requires contributions to the Fund or to any other health and welfare plan maintained by the Bricklayers and Allied Craftworkers International Union or any of its affiliated local unions); (B) the Employee is employed by an Employer who has been determined by the Trustees to be chronically delinquent in the payment of contributions to the Fund; or (C) the Employee temporarily transfers to the jurisdiction of another health and welfare plan maintained by the Bricklayers and Allied Craftworkers International Union or any of its affiliated local unions which is not party to a reciprocal agreement with the Fund.

Before suspending an Employee's use of the Hour Bank, the Fund will provide the Employee notice of the suspension at least ten (10) days prior to the suspension's effective date. The use of the Hour Bank will be reinstated only if the Employee demonstrates to the satisfaction of the Trustees that the conditions which led to the suspension have been corrected.

- (3) *Loss of Hour Bank Upon Termination of Employment.* An Employee shall permanently lose the hours he or she has accumulated in the Hour Bank if the Employee: (A) severs employment in the brick and trowel trades industry; or (B) permanently transfers to the jurisdiction of another health and welfare plan maintained by the Bricklayers and Allied Craftworkers International Union or any of its subsidiary local unions.
- (4) *Loss of Hour Bank as the Result of Fraud.* An Employee who engages in fraud against the Fund, including working for cash or otherwise accepting the payment of wages in a manner other than through an Employer's payroll system, will permanently lose the hours he or she has accumulated in the Hour Bank. Such permanent loss will be retroactively effective to the date the fraud first occurred.

(c) Continuing Eligibility by Making Self-Payments

If an Employee is in danger of losing eligibility due to insufficient hours of Covered Employment or a lack of available hours in the Hour Bank, the Fund will allow the Employee to maintain eligibility by making self-payments to the Fund for a single month. Thereafter, you must reestablish eligibility under the Fund by working at least 100 hours. You may use this self-payment option up to three times in a calendar year. The monthly self-payment rate is set by the Board of Trustees and may be adjusted from time to time.

If you are not working the minimum number of hours in order to continue eligibility under the Plan, you should contact the Fund Office to determine the current monthly self-payment rate and to request a self-payment form. At this time, the monthly self-payment will be the current hourly contribution rate set forth in the Collective Bargaining Agreement multiplied by the number of hours by which you are short of 100 hours for the month. You must have worked at least one hour during the month in order to be eligible to make a self-payment.

The Plan will accept self-payments only if you sign a self-payment form approved by the Trustees certifying that:

- (1) You are available for work under the jurisdiction of the Union – the Union must certify to the Fund that you are actively seeking employment in its jurisdiction as part of this process; and
- (2) You are not able to satisfy the minimum hours requirement for eligibility under the Plan because there is no work available for which you are qualified or which you can reasonably be expected to accept.

The self-payment form may be obtained from the Fund Office. Your completed form and your first monthly self-payment payment are due in the Fund Office on or before the first day of the month for which you are seeking coverage. You must work at least one hour in a month in order to be eligible for self-pay.

You may not use this self-payment option for more than one consecutive month at a time and no more than three times within a calendar year.

Once you again work at least 100 hours in Covered Employment, your coverage will continue under the Standard Rule previously described in this booklet.

It is important to remember that late self-payments will not be accepted. If you fail to submit a timely self-payment, the Fund will not accept further self-payments, in which case your eligibility will terminate. It is your responsibility to know when your eligibility for benefits is about to terminate, and it is your responsibility to submit the completed form and self-payment on time to prevent termination of eligibility.

(d) Maintaining Eligibility While Disabled

If an Eligible Employee becomes disabled, the Employee may extend his or her eligibility for a period up to twenty-six (26) weeks. For purposes of this subsection, an Employee is considered disabled if the Employee is unable to work in Covered Employment in the brick and trowel trades industry as the result of a medical disability. The Trustees have the exclusive authority and discretion to determine whether an Employee is disabled and may require appropriate medical and other documentation to establish the existence of the disability.

In order to be eligible for disability benefits, an Employee must be eligible for benefits based on Covered Employment or banked hours at the time of the injury or illness giving rise to the disability.

If the Employee's disability is resolved and the Employee returns to Covered Employment prior to the exhaustion of the twenty-six (26) week maximum disability eligibility period, the Employee's eligibility will continue under the Plan's continuing eligibility provisions. However, if the Employee remains disabled and does not return to Covered Employment before the exhaustion of the twenty-six (26) week maximum disability eligibility period, the Employee's eligibility will terminate and the Employee will be required to meet the Plan's requirements for reinstating eligibility.

(e) COBRA Payments

An Eligible Employee may also continue his or her coverage under the Plan if he or she makes the appropriate COBRA payments, as set forth in Chapter 3, in the manner and in the amount established, as may be changed from time to time, by the Board of Trustees.

2.03 ELIGIBILITY FOR DEPENDENTS

(a) In General.

A dependent of an Employee or Retiree will become an Eligible Dependent under the Plan upon the later of the effective date of the Employee's or Retiree's eligibility, or the date the dependent becomes an Eligible Dependent. "Eligible Dependent" means—

- (1) An Eligible Employee's or Eligible Retiree's spouse; or
- (2) An Eligible Employee's or Eligible Retiree's natural, legally adopted, or step-child until such child's attainment of age 26 regardless of that child's financial dependency on the Eligible Employee or Eligible Retiree, residency with the Eligible Employee or Eligible Retiree, student status, marital status, or employment.

- (3) An Eligible Employee's or Eligible Retiree's natural, legally adopted, or step-child who has been determined to be incompetent due to a mental or physical disability and who receives 50% or more of his or her support from the Eligible Employee or Eligible Retiree.
- (4) A grandchild of an Eligible Employee or Eligible Retiree who is under the age of 19 where the grandchild resides with the Eligible Employee or Eligible Retiree on a full-time basis and who receives 50% or more of his or her support from the Eligible Employee or Eligible Retiree.
- (5) The child of an Eligible Employee whose coverage under this Plan is established in accordance with a QMCSO.

No dependent may be eligible for coverage as an Eligible Dependent of more than one Eligible Employee. Additionally, no dependent may be eligible for coverage as an Eligible Dependent and an Eligible Employee at the same time.

(b) Continued Eligibility for Eligible Dependents of Deceased Employees

The Eligible Dependent(s) of a deceased Eligible Employee may utilize such Employee's Hour Bank, if any, to continue eligibility under this Plan. Upon exhaustion of the Hour Bank, if any, the Eligible Dependent(s) will remain eligible for an additional twelve (12) consecutive calendar months. Following exhaustion of the additional twelve (12) consecutive calendar months eligibility period, the Eligible Dependent(s) will be offered up to a maximum of thirty-six (36) months of additional COBRA Continuation Coverage.

(c) Special Rule for Children Covered by a QMCSO

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree, or order issued by a court of competent jurisdiction or by a state administrative body that has the force of a court judgment, decree, or order. To be a QMCSO, a judgment, decree or order must require a child to be enrolled in the Plan as a form of child support or health benefit coverage pursuant to state domestic relations law or enforce a state law relating to medical child support. To be a QMCSO, an order must include:

- (1) The name and last known address (if any) 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 which the order pertains, and
- (3) The name of the Plan.

An order will not be a QMCSO if it requires the Plan to provide any type or form of benefit not otherwise provided under the Plan except to the extent necessary to comply with a state law relating to medical child support orders.

The Plan is required to recognize QMCSOs. Upon receipt of an order or notice ("order") that may be a QMCSO, the Plan will notify, in writing, the Eligible Employee and each child covered by the order ("alternate recipients") that the order has been received. The Fund Office will determine whether the order is a QMCSO within thirty (30) days of receipt. If the order is determined to be a QMCSO, the Fund Office will notify, in writing, the Eligible Employee and the alternate recipient(s) of this determination. If the order is determined not to be a QMCSO, the Fund Office will notify, in writing, the Eligible Employee and the alternate recipient(s) of this determination and include a detailed description of why this determination was made.

Benefits under a QMCSO will be provided only so long as the QMCSO is in effect and the Eligible Employee maintains eligibility for benefits. Benefits for the alternate recipient(s) will terminate upon either the termination of the QMCSO or the termination of the Eligible Employee's eligibility. In either event, the alternate recipient(s) will be provided the right to continue coverage under COBRA.

2.04 ELIGIBILITY FOR RETIREES

(a) In General

The term "Retiree" means an Employee who has retired from working in Covered Employment with an Employer and who has applied for and has been determined to be eligible for retirement under a pension plan maintained by the Bricklayers and Allied Craftworkers International Union or any affiliated local union thereof. "Eligible Retiree" means a Retiree who satisfies the eligibility requirements for Retirees under this Plan set forth below.

(b) Eligibility Requirements

Retirees are eligible for benefits under this Plan only if the Retiree was a participant in a predecessor local union health and welfare fund that provides retiree health and welfare benefits under an agreement with and through this Fund and meets the eligibility requirements for retiree benefits under the predecessor plan. Retirees must also meet the following requirements:

- (1) The Retiree must retire between the ages of 62 and 65 or retire upon the occurrence of a disability. For those Retirees who retire between the ages of 62 and 65, eligibility will terminate upon reaching age 65. For those Retirees who retire based upon the occurrence of a disability, eligibility will terminate on the earlier of the third anniversary of the Retiree's retirement or upon becoming eligible for Medicare.
- (2) The Retiree must have been a participant in a "predecessor local health and welfare plan" as of April 30, 1997. The term "predecessor local health and welfare plan" refers to a health and welfare plan maintained by one of the predecessor local unions that merged to form the Bricklayers and Allied Craftworkers Local 1 of PA/DE.
- (3) The Retiree must have been an Eligible Employee of this Plan as of the date of his or her retirement.
- (4) Contributions must be paid to this Fund by the predecessor local health and welfare plan in such amounts as are required to maintain continuing monthly eligibility as determined by the Trustees of this Plan. Such payments must be made by the predecessor local health and welfare plan and cannot be made by the Retiree.

2.05 TERMINATION OF ELIGIBILITY

(a) In General

Except as otherwise provided herein, eligibility for benefits for an Eligible Employee and his or her Eligible Dependent(s) under the Plan will terminate upon the occurrence of any the following:

- (1) Failure of the Employee to complete enough hours of Covered Employment to continue eligibility.
- (2) Failure of the Employer to pay required contributions. The Trustees may, however, in their sole discretion, determine to maintain an Employee's eligibility where the Employee provides proof of continued Covered Employment during the period at issue.
- (3) Termination of Covered Employment with a participating Employer in the brick and trowel trades industry or retirement.
- (4) Exhaustion of the Employee's Hour Bank.
- (5) Entry into the Uniformed Services.
- (6) Exhaustion of COBRA Continuation Coverage or the failure to elect COBRA Continuation Coverage.

- (7) Eligibility for Medicare.
- (8) Exhaustion of any periods of extended benefits otherwise provided by the Plan.
- (9) Employment with an employer in the brick and trowel trades industry who does not maintain this Plan (i.e., is not signatory to a collective bargaining agreement which requires payment of contributions to this Fund or to another health and welfare plan that is party to a reciprocal agreement with this Fund).
- (10) The commission of fraud against the Fund. Fraud includes, but is not limited to, working for cash or otherwise accepting the payment of wages in a manner other than through an Employer's payroll system. Termination on the basis of fraud will be retroactively effective to the date the fraud first occurred.
- (11) The date the Plan is terminated.

A Covered Person whose benefits would have terminated under (1) above but who maintained continued coverage through the use of the Hour Bank, self-payments, or COBRA Continuation Coverage is entitled to resume continuing monthly eligibility upon resumption of Covered Employment without regard to any Reinstatement of Coverage requirements.

(b) Additional Termination Events for Dependents

The date the dependent ceases to qualify as an Eligible Dependent pursuant to either the terms of this Plan or the terms of a Plan amendment.

(c) Additional Termination Events for Retirees

- (1) The date the Retiree ceases to qualify as an Eligible Retiree pursuant to either the terms of this Plan, the terms of a Plan amendment, the terms of the Retiree's predecessor local health and welfare plan, or the terms of an amendment to the Retiree's predecessor local health and welfare plan.
- (2) Failure of the Retiree's predecessor local health and welfare plan to pay contributions to this Fund in such amounts as required to maintain continuing monthly eligibility as determined by the Trustees of this Plan.

(d) Effect of Termination of Eligibility

Upon termination of eligibility, benefits shall not be payable under the Plan except for Covered Expenses for Covered Services Incurred prior to the date eligibility terminates.

2.06 REINSTATEMENT OF COVERAGE

(a) In General

Except as otherwise provided for in the Plan, if an Employee's eligibility is terminated, his or her status as an Eligible Employee will be reestablished as of the first day of the second month immediately following a consecutive 12-month period in which the Employee completes 750 hours of Covered Employment for which contributions are required to be made to the Fund on his or her behalf by his Employer(s).

(b) Special COBRA Continuation Coverage Rule

If an Employee's eligibility terminates because he or she forgoes COBRA Continuation Coverage in favor of alternative coverage, such as coverage through the PPACA marketplace or coverage through his or her spouse's plan, the Employee may resume continuing monthly eligibility upon resumption of Covered Employment without regard to any Reinstatement of Coverage requirements so long as the Employee

actively seeks Covered Employment after his or her eligibility terminated.

(c) Periods of Substantial and Ongoing Unemployment

In the event of substantial and ongoing unemployment in the brick and trowel trades industry, as determined by the Trustees in their sole discretion, the Trustees may suspend the consecutive 12-month limitation period in which the 750 hours of Covered Employment must be accrued provided that such suspension shall be reviewed and re-determined by the Trustees at the second quarterly meeting of the Trustees after the suspension and each extension thereof. A termination of the suspension shall be effective 90 days after the decision of the Trustees.

2.07 ELIGIBILITY DURING /AFTER PERIODS OF MILITARY SERVICE

(a) When You Leave Covered Employment

An active Employee who enters the Uniformed Services as defined in the Uniformed Services Employment and Reemployment Rights Act (USERRA) for active military duty or training, inactive duty or training, full-time National Guard or Public Health Service duty, or fitness-for-duty examination, may elect to continue his or her coverage (and the coverage of his or her Eligible Dependent(s), if any) by giving notice to the Fund Office thirty (30) days in advance of commencing the Uniformed Service. The time period for the notice will be waived where such notice is impossible, unreasonable or precluded by military necessity.

The failure to give notice of Uniformed Service and to elect continuation of benefits will result in the termination of benefits as otherwise provided under the terms of the Plan. An Employee who gives timely notice of Uniformed Service but does not initially elect to continue benefits shall have up to 90 days from the commencement of Uniformed Service to elect to continue benefits.

(b) While You Are Engaged in Uniformed Service

An Employee who elects to continue his or her coverage (and the coverage of his or her Eligible Dependent(s), if any) under this Section has the right to extend his or her coverage for the shorter of twenty-four (24) months from the commencement of Uniformed Service or the period from the commencement of Uniformed Service until the date the employee fails to return from the service or to apply for reemployment (usually within 90 days after the end of such Uniformed Service or as otherwise permitted under the Act).

For the first 30 days of Uniformed Service, the Fund will cover the cost of continuation coverage for the employee and, where applicable, the employee's eligible dependents. Commencing with the 31st day of Uniformed Service, the employee must pay the cost of continuation coverage in such amounts as determined by the Trustees which shall not exceed 102% of the actual premiums. The failure of the employee to pay required costs, including the cost of retroactive coverage, within 90 days after the commencement of Uniformed Service will result in the termination of eligibility as otherwise provided under the Plan.

An Employee may elect to use available hours in his or her Hour Bank to meet the continuing eligibility requirements of the Plan, but upon exhaustion of available banked hours must make payments as required herein to maintain continued eligibility. Any banked hours not so utilized will remain in the Employee's Hour Bank consistent with the terms of the Plan.

Notwithstanding anything in the above paragraph to the contrary, however, in the event of a declaration of war or the existence of an armed conflict involving the United States, as determined by Congress or by the President of the United States as permitted under law, the Fund will pay the cost of continuation coverage for an Employee who commences Uniformed Service, and for the Employee's Eligible Dependents where applicable, where the Employee is an active Covered Person in the Plan at the time of commencement of

Uniformed Service. Such continuation coverage at the expense of the Plan shall commence upon entry of the Employee into Uniformed Service and shall continue for the shorter of a period of two (2) years or until the Employee returns from Uniformed Service.

(c) When You Return to Covered Employment

If you meet the requirements of USERRA (see below), Plan coverage for you and your Eligible Dependents will be reinstated on the day you return to work in Covered Employment. The requirements of USERRA that you must meet to be covered by this section include:

- (1) You (or an appropriate military officer) must give advance written or oral notice to your Employer that you are entering uniformed service (unless such advance notice is impossible, unreasonable or precluded by military necessity);
- (2) You must not be dishonorably discharged upon the conclusion of the Uniformed Service;
- (3) The cumulative length of all of your absences with the employer due to Uniformed Service must generally be no longer than five (5) years.
- (4) Upon leaving the Uniformed Service, you must report back to your pre-service Employer for reemployment and/or report to the Union for a referral to Covered Employment within the following specified periods of time:
 - (A) Uniformed service of less than 31 days, or for any length for a fitness for duty examination: You must generally report for work on the first regularly-scheduled workday at least 8 hours after you arrive home from service.
 - (B) Uniformed service of more than 30 days, but less than 181 days: You must generally report for work within 14 days after completion of service.
 - (C) Uniformed service of more than 180 days: you must report for work within 90 days after completion of the service.

An Employee who fails to return to Covered Employment within the time periods listed above will be required to meet the Plan's Reinstatement of Coverage requirements.

2.08 ELIGIBILITY DURING FMLA LEAVE

The FMLA entitles employees eligible under the FMLA to take up to 12 weeks of unpaid, job-protected leave each year for the employee's own illness, or to care for a seriously ill child, spouse or parent. In addition, the FMLA provides leave for the birth or placement of a child with the employee in case of adoption or foster care. Employees eligible for leave under the FMLA are those who have been employed at least 12 months by the employer and who have provided at least 1,250 hours of service to the employer. An employee at a work site at which there are fewer than 50 employees is not eligible for FMLA leave unless the total number of employees of that employer within a 75 mile radius of the employee is 50 or more.

Employers covered by the FMLA are required to maintain medical coverage for employees on FMLA leave whenever such coverage was provided before the leave was taken, and on the same terms as if the employee had continued to work. This means that an Employer is required to continue making contributions to the Fund on behalf of an Employee on FMLA leave.

An Employee who is granted leave under the FMLA by his or her Employer will continue to be eligible for benefits under this Plan notwithstanding the fact that the Employee is not actively employed in Covered Employment so long as the Employer continues to pay contributions as are necessary to continue monthly eligibility. The status

of the Employee and the Employee's Eligible Dependents as Covered Person in this Plan shall continue for the duration of such leave provided the required contributions are paid by the Employer. If the Employee returns to Covered Employment upon termination of the leave, the Employee shall be entitled to continue monthly eligibility without regard to any Reinstatement of Coverage requirements.

Contact the Fund Office if you are planning to take FMLA leave so that the Fund is aware of your Employer's responsibility to report the period of your absence. In addition, if you have any questions about the FMLA, you should contact your Employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under the U.S. government, Department of Labor, Employment Standards Administration or visit the Department of Labor's website.

CHAPTER 3—RIGHT TO COBRA CONTINUATION COVERAGE

3.01 COBRA CONTINUATION COVERAGE

If coverage under this Plan is scheduled to end because of certain events referred to as Qualifying Events, a Covered Person can pay to continue benefits for a limited period. This extended coverage is called COBRA Continuation Coverage and is available to both Eligible Employees and Eligible Dependents who are covered by this Plan on the day before the Qualifying Event.

Individuals who have the right to elect COBRA Continuation Coverage are called Qualified Beneficiaries. A Qualified Beneficiary who elects COBRA Continuation Coverage is responsible for paying the full cost of this coverage once all other coverage under this Plan ends. The COBRA rates are established by the Trustees and can change from time to time.

This Chapter explains what COBRA Continuation Coverage is, when it may become available to you and your family, and what you need to do to protect your right to get it. However, when you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA Continuation Coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

3.02 COBRA RULES FOR EMPLOYEES

An Eligible Employee may choose COBRA Continuation Coverage for the Eligible Employee, the Eligible Employee's spouse and/or the Eligible Employee's Eligible Dependent children. COBRA Coverage can be continued for up to 18 months from the date the Eligible Employee would lose coverage under the Plan because the Employee terminates employment covered by this Plan (for reasons other than gross misconduct) or because the Employee does not have sufficient hours of Covered Employment for which contributions are due to the Fund to continue eligibility.

Under certain circumstances a disabled person and his or her family may extend coverage for a total of 29 months following termination of employment or a reduction in hours of employment. To qualify for the additional 11 months of coverage the disabled person must have a determination of disability from the Social Security Administration effective within 60 days of the termination of employment or reduction in hours of employment. The determination from the Social Security Administration must be filed with the Fund Office within 60 days of the date the determination is made. The extended COBRA Continuation Coverage applies to the disabled individual and all covered non-disabled family members.

If individuals receive extended COBRA Continuation Coverage because of a disability, the disabled person must also notify the Fund Office within 30 days of a final determination by the Social Security Administration that the person is no longer disabled. COBRA Continuation Coverage ends if Medicare coverage begins before the 29-month period expires or if the disabled person recovers from the disability and has already received 18 months of COBRA Continuation Coverage.

3.03 COBRA RULES FOR DEPENDENTS

If an Employee chooses not to purchase COBRA Continuation Coverage, the Participant's spouse and/or Eligible Dependent children may separately purchase COBRA Continuation Coverage for themselves by making the election and the required monthly premium payments.

The COBRA Continuation Coverage for Eligible Dependents can be continued for up to 18 months (29 months if

there is a disabled person electing coverage) if coverage would otherwise end because of the termination of an Employee's Covered Employment or a reduction in the Employee's hours of Covered Employment. However, coverage can be continued for up to 36 months for the Employee's spouse and Eligible Dependent children if their coverage would otherwise end because of:

- (a) The death of the Employee;
- (b) The divorce of the Employee and spouse;
- (c) A child's loss of status as an "Eligible Dependent" under the Plan; or
- (d) The Employee becomes entitled to Medicare.

Generally, the maximum period of COBRA Continuation Coverage for an Employee's dependents is 36 months from the date the Employee's spouse or Eligible Dependent children would otherwise lose eligibility under the Plan due to one of the events listed above, even if two or more of these events occur.

3.04 NOTICE REQUIREMENTS FOR COBRA CONTINUATION COVERAGE

(a) Employee / Eligible Dependent

- (1) An Employee, spouse, or Eligible Dependent child must notify the Fund Office in writing within 60 days of a divorce or a child's loss of Eligible Dependent status.
- (2) An Employee, spouse, or Eligible Dependent child must notify the Fund Office in writing of a determination by the Social Security Administration that a Covered Person was disabled during the 60 day period after the Employee's termination of employment or reduction in hours, within 60 days of such determination and before the end of the initial 18 month continuation coverage period. If, during extended disability coverage, the Social Security Administration determines that the Covered Person is no longer disabled, the Covered Person must inform the Fund Office of this redetermination within 30 days of the date it is made.
- (3) A spouse or Eligible Dependent child of an Employee should notify the Fund Office within 60 days of that Employee's death.

(b) Employer

An Employer must notify the Fund Office within 60 days of an Employee's death or eligibility for Social Security benefits.

(c) Fund Office

The Fund Office will determine when an Employee's eligibility for benefits would end due to the termination of Covered Employment or reduction in hours of Covered Employment for which contributions are due to the Fund.

Following the Fund Office's receipt of a notice described in subsections (a) or (b), or after an Employee's loss of eligibility due to termination of Covered Employment or reduction in hours of Covered Employment, the Fund Office will notify Employees, their spouses or Eligible Dependent children of their right to elect COBRA Continuation Coverage.

3.05 ELECTION OF COBRA CONTINUATION COVERAGE

To elect COBRA Continuation Coverage, an Employee, spouse or Eligible Dependent child must complete an election form provided by the Plan and submit it to the Fund Office within 60 days after the later of the date eligibility for benefits would otherwise end or the date the Employee, spouse or Eligible Dependent child receives the notice of the right to elect COBRA Continuation Coverage.

3.06 REQUIRED PREMIUMS

The premium(s) for COBRA Continuation Coverage are established by the Trustees and can change from time to time. A Covered Person who has elected COBRA Continuation Coverage will be notified of the applicable premium(s) and payment options. Premium(s) for COBRA Continuation Coverage become payable 45 days after the day on which the Covered Person elects to obtain COBRA Continuation Coverage.

3.07 TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA Continuation Coverage may terminate earlier than the maximum period (18, 29 or 36 months) if:

- (a) All health benefits provided by the Plan terminate.
- (b) An Employee, Employee's spouse or Eligible Dependent child who has elected COBRA Continuation Coverage does not make the required payments to the Fund Office on time.
- (c) An Employee who has elected COBRA Continuation Coverage becomes covered by Medicare.
- (d) An Employee, Employee's spouse or Eligible Dependent child becomes covered by another group health plan after the loss of coverage from this Plan, unless the replacement plan limits coverage due to pre-existing conditions, and the pre-existing condition limitation actually applies to the Employee, spouse or child after your coverage under this Plan is taken into account.
- (e) Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Once COBRA Continuation Coverage terminates, it cannot be reinstated.

CHAPTER 4—MEDICAL BENEFITS

PART A – GENERAL INFORMATION REGARDING YOUR MEDICAL BENEFITS

Part A of this Chapter is designed to educate you about how to access medical care covered by the Plan. It is also designed to inform you about how financial responsibility for such care is allocated between you and the Fund. It addresses topics such as:

- How to access medical care through the Personal Choice Network of Independence Blue Cross.
- The distinctions between In-Network and Out-of-Network care.
- The importance of staying In-Network to minimize your expenses and the Fund’s expenses.
- The meaning of four key terms, including: (a) Deductible; (b) Out-of-Pocket Maximum; (c) Coinsurance; and (d) Copayment.
- The Deductibles and Maximums that apply to In-Network and Out-of-Network care.
- ***Perhaps most importantly, Part A includes the Schedule of Benefits available to you under the Plan.***

Part B of this Chapter provides additional information regarding the types of Covered Services included in the Schedule of Benefits. Part C of this Chapter describes the Fund’s rules regarding when you must obtain Preapproval to ensure that proposed services are Medically Necessary and covered. Part C also describes the Fund’s utilization review process. Finally, Part D of this Chapter include applicable definitions along with a listing of the types of providers covered under the Plan.

You should note that capitalized terms used in this Chapter and throughout the Plan have special meaning. In most cases, these terms are defined in Chapter 1 of the Plan. However, where a term is specific to a particular type of covered benefit, the term is defined in the Section of the Plan that describes such benefit. Finally, you should also note that Chapter 5 describes what is excluded from coverage under the Plan.

As always, if you have any questions regarding the Plan or the manner in which the Fund operates, feel free to contact the Fund Office at (215) 856-9663.

4.01 INDEPENDENCE BLUE CROSS / PERSONAL CHOICE NETWORK

(a) In General

The Fund is party to a preferred provider organization network administration agreement with Independence Blue Cross. Pursuant to that agreement, Independence Blue Cross provides Covered Persons with access to the Personal Choice Network. The Personal Choice Network is designed to make available quality care through a select group of Providers.

(b) How to Use the Personal Choice Network / Your Identification Card

Covered Persons will each receive an Independence Blue Cross identification (ID) card. Your ID card verifies your participation in the Personal Choice Network. It is important to take your ID card with you wherever you go because it contains information like what to pay when visiting your doctor or the emergency room (ER). You should present your ID card whenever you seek medical care.

The back of your ID card provides information about medical services, what to do in an emergency situation, and how to use your benefits when you seek care outside of the Personal Choice Network. If any information on your ID card is incorrect, you misplace it, or need to print out a temporary ID card, you may do so through www.ibxpress.com. You may also call 1-800-ASK-BLUE (1-800-275-2583) or the Fund Office.

(c) Finding a Provider in the Personal Choice Network (i.e., Finding an In-Network Provider)

The Personal Choice Network provides Covered Persons with access to an expansive group of Providers. You can search the Personal Choice Network by going to www.ibx.com/providerfinder. You may search by specialty (for example, internal or pediatrics), location, gender preference, and distance. You may also call 1-800-ASK-BLUE (1-800-275-2583) and a customer service associate will help you locate a Provider.

(d) Traveling Outside of the Personal Choice Network / The BlueCard PPO Program

The service area of Independence Blue Cross covers the following Pennsylvania counties: (1) Bucks; (2) Chester; (3) Delaware; (4) Montgomery; and (5) Philadelphia. However, under the BlueCard PPO Program, Covered Persons who require care outside of these counties may access the preferred network of the Blue Cross Blue Shield company that serves the area where the care is rendered. This means you can travel with peace of mind knowing that, if you need to see a Physician or go to the Hospital, you can simply present your ID card to any BlueCard PPO Provider across the country.

(e) Managing Your Healthcare Online

Covered Persons 18 years of age and older can conveniently and securely view their benefits and claims information and access several useful online tools at www.ibx.com.

4.02 ALLIED TRADES ASSISTANCE PROGRAM (ATAP)

The Fund has partnered with the Allied Trades Assistance Program (ATAP) to make available an expansive list of alcohol or drug abuse dependency and mental health providers to Covered Persons in need of assistance.

The ATAP was created by the Philadelphia Building Trade Unions to contain costs and promote improved service delivery for drug and alcohol abuse, mental health concerns and related issues to Covered Persons and their families. The staff at ATAP is directly responsive to the specific needs in providing personal, confidential, and appropriate referral and follow-up services.

If you have any questions about your coverage or questions about services and providers, please visit ATAP's website at www.alliedtrades-online.com or call ATAP directly. ATAP staff are available by telephone Monday through Friday from 8:30 a.m. to 4:00 p.m. at #215-677-8820/Toll Free #800-258-6376 or by email at eat@alliedtrades-online.com. If you contact ATAP after hours, ATAP's on-call service can provide support and referral to services needed. In addition, if you wish to speak with a ATAP staff person, you can request to have a staff person paged.

When you contact ATAP, ATAP staff will complete an assessment to obtain information pertaining to the presenting issue, substance abuse history/current use amount and frequency, legal issues, medical issues, past treatment history and any current concerns specific to treatment. Thereafter, you will discuss treatment provider options. If you are having a difficult time during your stay in treatment, the facility should contact both the ATAP reviewer along with the EAP assigned to the case.

4.03 IN-NETWORK / OUT-OF-NETWORK

(a) You Must Remain In-Network to Receive Maximum Benefits

Covered Services may be provided by either an In-Network or Out-of-Network Provider. When a Covered Person seeks care from an In-Network Provider, the Fund will provide benefits at the In-Network Coinsurance and/or Copayment level specified in the Schedule of Benefits. When a Covered Person seeks care from an Out-of-Network Provider, the Fund will provide benefits at the Out-of-Network Coinsurance and/or Copayment level specified in the Schedule of Benefits.

To receive maximum benefits available under the Plan, Covered Persons must obtain Covered Services from an In-Network Provider. In other words, Covered Persons must use a Provider that participates in the

Personal Choice Network or qualifies as a BlueCard PPO Provider. Covered Persons will save money (and will save the Fund money) if they remain within the Personal Choice Network.

(b) You May Pay More if You Use an Out-of-Network Provider / Risk of Balance Billing

If a Covered Person uses an Out-of-Network Provider, the Fund will pay for the Covered Services in accordance with the Plan, but the Covered Person may incur significantly higher out-of-pocket expenses, including Deductibles and a higher Coinsurance percentage. **In certain instances, the Out-of-Network Provider also may charge the Covered Person for the remainder (or “balance”) of the Provider’s bill after applying payment from the Fund—this practice is often referred to as *balance billing*.** This is true whether the Covered Person uses an Out-of-Network Provider by choice, for level of expertise, for convenience, for location, because of the nature of the services, or based on the recommendation of a Provider. However, the Covered Person will be held harmless for Out-of-Network differentials if an In-Network Provider fails to provide written notice to the Covered Person of the Provider’s Out-of-Network status for certain services, or an In-Network Provider provides a written order for certain services to be performed by an In-Network Provider that has Out-of-Network status for those services and that Provider performs such services.

(c) Out-of-Network Services Treated as In-Network

In certain cases services provided by an Out-of-Network Provider will be subject to the In-Network cost-sharing levels set forth in the Schedule of Benefits. For example, Emergency Care is covered at the Plan’s In-Network cost-sharing levels. Additionally, when a Covered Person receives Covered Services from an Out-of-Network Hospital-Based Provider while the Covered Person is an Inpatient at an In-Network Facility Provider and is being treated by an In-Network Professional Provider, the Covered Person will receive the In-Network cost-sharing level of benefits for the Covered Services provided by the Out-of-Network Hospital-Based Provider.

4.04 DEDUCTIBLES / MAXIMUMS / COINSURANCE / COPAYMENTS

(a) Schedule of Calendar Year Deductibles & Maximums

DEDUCTIBLES & MAXIMUMS	IN-NETWORK	OUT-OF-NETWORK
Individual Deductible	None	\$1,500
Family Deductible	None	\$4,500
Individual Out-of-Pocket Maximum	None	\$10,000
Family Out-of-Pocket Maximum	None	\$30,000
Annual Maximum	None	None
Lifetime Maximum	None	None

(b) Deductibles

The term Deductible refers to the amount of Covered Expenses that a Covered Person must pay each calendar year before the Plan pays benefits. Benefits provided on an In-Network basis are not subject to a Deductible. However, benefits provided on an Out-of-Network basis are subject to the Deductibles listed in subsection (a) above. An Out-of-Network Deductible will not be applied to any covered family member once that covered family member has satisfied the individual Out-of-Network Deductible, or the family Out-of-Network deductible has been satisfied for all covered family members combined.

(c) Maximums

(1) *Out-of-Pocket Maximum.* The term Out-of-Pocket Maximum refers to a specified maximum dollar amount of Covered Expenses Incurred and paid for by a Covered Person during a Plan Year. For purposes of the Plan’s Out-of-Network Out-of-Pocket Maximums, the maximums include Coinsurance but do not include Copayments, Deductibles, penalties, or amounts that exceed Covered Expenses.

- (2) *Maximum.* The term Maximum refers to a limit on the amount of Covered Services that a Covered Person may receive. A Maximum may apply to all Covered Services or selected types. When the Maximum is expressed in dollars, this Maximum is measured by the Covered Expenses, less Deductibles, Coinsurance and Copayment amounts paid by Covered Persons for the Covered Service to which the Maximum applies. The Maximum may not be measured by the actual amounts paid by the Fund to Providers. A Maximum may also be expressed in number of days or number of services for a specified period of time.

(d) Coinsurance

The term Coinsurance refers to a type of cost-sharing whereby the Covered Person assumes responsibility for a percentage of the Covered Expenses for a Covered Service. It is the amount a Covered Person must pay for covered medical services after the Covered Person has satisfied any applicable Copayment or Deductible. The Coinsurance rates for specific covered services are listed in the Schedule of Benefits.

(e) Copayments or Copays

The term Copayment refers to a type of cost-sharing whereby the Covered Person pays a flat dollar amount each time a Covered Service is provided. The Copayment rates for specific covered medical services are listed in the Schedule of Benefits.

4.05 SCHEDULE OF BENEFITS

This Section provides general information regarding the medical services covered under the Plan. Subject to the Plan’s exclusions, conditions and limitations, a Covered Person is entitled to benefits for the Covered Services listed in the following chart, subject to the cost-sharing rules set forth in the middle and right-hand columns.

BENEFIT	YOUR COST IF YOU USE AN IN-NETWORK PROVIDER	YOUR COST IF YOU USE AN OUT-OF-NETWORK PROVIDER
Alcohol or Drug Abuse and Dependency Inpatient Detoxification Hospital and Non-Hospital Residential Care Outpatient Treatment	None	50%, after Deductible*
	None	50%, after Deductible*
	\$20 Copay/Visit	50%, after Deductible
*Out-of-Network Calendar Year Maximum: 70 Inpatient days. This maximum is combined for all Out-of-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol or Drug Abuse and Dependency Benefits. The Provider Network for Alcohol or Drug Abuse and Dependency is furnished by ATAP.		
Ambulance Services Emergency Services Non-Emergency Services	None	None, no Deductible
	None	50%, after Deductible
Autism Spectrum Disorders*	Same cost-sharing as any other medical service within the applicable medical service category.	Same cost-sharing as any other medical service within the applicable medical service category.
*Annual Benefit Maximum for non-Essential Health Benefits provided with respect to an Autism Spectrum Disorder is \$38,276. The Plan’s benefit period maximums and visit limits associated with applicable medical service categories do not apply.		
Blood	None	50%, after Deductible
Colorectal Cancer Screening	None	50%, after Deductible

Day Rehabilitation Program*	None	50%, after Deductible
*Subject to a combined limit of 30 In-Network through ATAP and Out-of-Network Visits per calendar year.		
Diabetic Education Program	None	Not Covered
Diabetic Equipment and Supplies	30%	50%, after Deductible
Diagnostic/Radiology Services – Non-Routine Including MRI/MRA, CT scans, PET scans	\$40 Copay/Date of Service	50%, after Deductible
Diagnostic/Radiology Services –Routine	\$20 Copay/Date of Service	50%, after Deductible
Durable Medical Equipment	30%	50%, after Deductible
Emergency Care Services	\$100 Copay/Visit	\$100 Copay/Visit
Home Health Care	None	50%, after Deductible
Hospice Services*	None	50%, after Deductible
*Respite Care: Limited to a combined limit of 7 In-Network and Out-of-Network Visits every 6 months.		
Hospital Services Facility Charge Professional Charge	None	50%, after Deductible*
	None	50%, after Deductible
*Out-of-Network Calendar Year Maximum: 70 Inpatient days. This maximum is combined for all Out-of-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol or Drug Abuse and Dependency Benefits.		
Immunizations	None	50%, no Deductible
Injectable Medications Specialty Drugs Standard Injectable Drugs	\$50 Copay/Injection	50%, after Deductible
	None	50%, after Deductible
Insulin and Oral Agents	Generic - \$10 Copay Brand - \$15 Copay	Generic - \$10 Copay Brand - \$15 Copay
Laboratory and Pathology Tests	None	50%, after Deductible
Artificial Inseminations	\$10 Copay/Visit	50%, after Deductible
Elective Abortions Professional Service Outpatient Facility Charges	\$10 Copay Per Provider Per Date of Service	50%, after Deductible
	None	50%, after Deductible
Maternity/Obstetrical Care Professional Service Facility Service Newborn Care	Single \$10 Copay	50%, after Deductible
	None	50%, after Deductible
	None	50%, after Deductible
Medical Care	None	50%, after Deductible
Medical Foods and Nutritional Formulas	None	50%, after Deductible
Mental Health/Psychiatric Care* Inpatient Outpatient	None	50%, after Deductible
	\$20 Copay/Visit	50%, after Deductible
*Out-of-Network Calendar Year Maximum: 70 Inpatient days. This maximum is combined for all Out-of-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol or Drug Abuse and Dependency Benefits. In-Network services are through ATAP.		

Non-Surgical Dental Services*	None	50%, after Deductible
*Limited to Dental Services as a Result of an Accidental Injury		
Nutrition Counseling for Weight Management*	None	50%, after Deductible
*Subject to a combined limit of 6 In-Network and Out-of-Network Visits per calendar year.		
Orthotics	30%	50%, after Deductible
Podiatric Care	\$20 Copay/Visit	50%, after Deductible
Preventive Care – Adult	None	50%, after Deductible
Preventive Care – Pediatric	None	50%, after Deductible
Primary Care Physician Office & Retail Clinic Visits	\$10 Copay/Visit	50%, after Deductible
Private Duty Nursing Services*	10%	50%, after Deductible
*Subject to a combined limit of 360 In-Network and Out-of-Network Inpatient hours per calendar year.		
Prosthetic Devices	30%	50%, after Deductible
Skilled Nursing Facility Services*	None	50%, after Deductible
*Subject to a combined limit of 120 In-Network and Out-of-Network Inpatient days per calendar year.		
Specialist Office Visits	\$20 Copay/Visit	50%, after Deductible
Spinal Manipulation Services*	\$20 Copay/Visit	50%, after Deductible
*Subject to a combined limit of 20 In-Network and Out-of-Network Visits per calendar year.		
Surgical Services*		
Outpatient Facility Charge	None	50%, after Deductible
Outpatient Professional Charge	None	50%, after Deductible
Outpatient Anesthesia	None	50%, after Deductible
Second Surgical Opinion	\$20 Copay/Opinion	50%, after Deductible
*If more than one surgical procedure is performed by the same Professional Provider during the same operative session, the Plan will pay 100% of the Covered Service for the highest paying procedure and 50% of the Covered Services for each additional procedure.		
Therapy Services		
Cardiac Rehabilitation Therapy*	\$20 Copay/Session	50%, after Deductible
*Subject to a combined limit of 36 In-Network and Out-of-Network sessions per calendar year.		
Chemotherapy	None	50%, after Deductible
Dialysis	None	50%, after Deductible
Infusion Therapy	None	50%, after Deductible
Orthoptic/Pleoptic Therapy*	\$20 Copay/Session	50%, after Deductible
*Subject to a combined lifetime limit of 8 In-Network and Out-of-Network sessions.		
Physical Therapy/Occupational Therapy*	\$20 Copay/Session	50%, after Deductible
*Subject to a combined limit of 30 In-Network and Out-of-Network sessions per calendar year. Limitation does not apply to the treatment of lymphedema related to mastectomy.		
Pulmonary Rehabilitation Therapy	\$20 Copay/Session	50%, after Deductible
*Subject to a combined limit of 36 In-Network and Out-of-Network sessions per calendar year.		
Radiation Therapy	None	50%, after Deductible
Speech Therapy	\$20 Copay/Session	50%, after Deductible
*Subject to a combined limit of 36 In-Network and Out-of-Network sessions per calendar year.		
Transplant Services*		

Inpatient Facility Charges	None	50%, after Deductible*
Outpatient Facility Charges	None	50%, after Deductible
*Out-of-Network Calendar Year Maximum: 70 Inpatient days. This maximum is combined for all In-Network Inpatient Hospital Services, Mental Health/Psychiatric Care and Treatment for Alcohol or Drug Abuse and Dependency Benefits.		
Urgent Care Centers	\$70 Copay/Visit	50%, after Deductible
Women’s Preventive Care*	None	50%, no Deductible
*Contraceptives mandated by the Women’s Preventive Services provision of PPACA are covered at 100% for generic products and for those products that do not have a generic equivalent. Brand contraceptive products are not covered.		

PART B – DETAILED INFORMATION REGARDING SPECIFIC COVERED BENEFITS

Part B of this Chapter provides additional information regarding the types of Covered Services included in the Schedule of Benefits. The order of the following Sections generally corresponds with the order in which Covered Services are listed in the Schedule of Benefits (i.e., alphabetically).

As previously noted, capitalized terms used in this Chapter and throughout the Plan have special meaning. In most cases, these terms are defined in Part D of this Chapter. However, where a term is specific to a particular type of covered benefit, the term is defined in the Section of the Plan that describes such benefit. Finally, you should also note that Chapter 5 describes what is excluded from coverage under the Plan.

As always, if you have any questions regarding the Plan or the manner in which the Fund operates, feel free to contact the Fund Office at (215) 856-9663.

4.06 ALCOHOL OR DRUG ABUSE AND DEPENDENCY

(a) In General

The term “Alcohol or Drug Abuse and Dependency” refers to the use of alcohol or other drugs which produces a pattern of pathological use that causes impairment in the way people relate to others, causes impairment in the way people function in their jobs or careers, or produces a dependency that makes a person physically ill when the alcohol or drug is taken away.

Subject to the Plan’s conditions, limitations and exclusions, the Plan covers the care and treatment of Alcohol or Drug Abuse and Dependency that is provided by a licensed Hospital, a licensed Facility Provider or an appropriately licensed behavioral health Provider.

(b) Covered Alcohol or Drug Abuse and Dependency Treatment

- (1) *Inpatient Detoxification.* Covered Services include: (A) Lodging and dietary services; (B) Physician, Psychologist, nurse, certified addictions counselor, Masters Prepared Therapists, and trained staff services; (C) Diagnostic x-rays; (D) Psychiatric, psychological and medical laboratory testing; and (E) Drugs, medicines, and the use of equipment and supplies.
- (2) *Hospital and Non-Hospital Residential Care.* Covered Services include: (A) Lodging and dietary services; (B) Physician, Psychologist, nurse, certified addictions counselor and trained staff services; (C) Rehabilitation therapy and counseling; (D) Family counseling and intervention; (E) Psychiatric, psychological and medical laboratory testing; and (F) Drugs, medicines, and the use of equipment and supplies.
- (3) *Outpatient Treatment.* Covered Services include: (A) Diagnosis and treatment of substance abuse, including Outpatient Detoxification by the appropriately licensed behavioral health Provider; (B)

appropriately licensed behavioral health provider including Physician, Psychologist, nurse, certified addictions counselor, Masters Prepared Therapists, and trained staff; (C) Rehabilitation therapy and counseling; (D) Family counseling and intervention; (E) Psychiatric, psychological and medical laboratory testing; and (F) Medication management and the use of equipment and supplies.

(c) Definition of Detoxification

The term “Detoxification” refers to the process by which a person who is alcohol or drug dependent, is assisted in a state licensed Facility Provider (or, in the case of opiates, by an appropriately licensed behavioral health provider, in an ambulatory (Outpatient) setting) to eliminate, by metabolic or other means, any or each of the following problems: (1) the intoxicating alcohol or drug; (2) alcohol or drug dependency factors; or (3) alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological and psychological risk to the patient at a minimum.

4.07 AMBULANCE SERVICES

(a) In General

The Plan covers ambulance services when Medically Necessary. The services must be used for transportation in a specially designed and equipped vehicle that is used to transport the sick or injured and only when the following applies: (1) the vehicle is licensed as an ambulance, where required by applicable law; (2) the ambulance transport is appropriate for the Covered Person’s clinical condition; (3) the use of any other method of transportation, such as taxi, private car, wheel-chair van or other type of private or public vehicle transport would endanger the Covered Person’s medical condition; and (4) the ambulance transport satisfies the destination and other requirements as stated under this Section.

(b) Additional Conditions

- (1) *Air or Sea Ambulance Transportation.* Benefits are payable for air or sea ambulance transportation only if the Covered Person’s condition, and the distance to the nearest facility able to treat the Covered Person’s condition, justify the use of an alternative to land transport.
- (2) *Regarding Emergency Ambulance Transport.* The ambulance must be transporting the Covered Person from the Covered Person’s home, or the scene of an accident or Medical Emergency, to the nearest Hospital or other Emergency Care Facility that can provide the Medically Necessary Covered Services to treat the Covered Person’s condition.
- (3) *Regarding Non-Emergency Ambulance Transport.* Non-Emergency air transport may be covered to return the Covered Person to an In-Network Facility Provider within a reasonable distance, as determined by the Fund, with the capability of treating the condition for which transfer is necessary within the Personal Choice Network or BlueCard PPO Program service area for required continuing care (when a Covered Service), when such care immediately follows an Inpatient emergency admission and the Covered Person is not able to return to the Personal Choice Network or BlueCard PPO Program service area by any other means. This type of transportation is provided when the Covered Person’s medical condition requires uninterrupted care and attendance by qualified medical staff during transport that cannot be safely provided by land ambulance. Transportation back to the Personal Choice Network or BlueCard PPO Program service area will not be covered for family members or companions.

4.08 AUTISM SPECTRUM DISORDERS

(a) In General

The Plan covers the diagnostic assessment and treatment of Autism Spectrum Disorders for Covered Persons under 21 years of age subject to the limitations set forth in the Schedule of Benefits. Diagnostic assessment is defined as Medically Necessary assessments, evaluations or tests performed by a licensed Physician, licensed Physician assistant, licensed Psychologist, Certified Registered Nurse practitioner, or Autism Service Provider to diagnose whether an individual has an Autism Spectrum Disorder. Results of the diagnostic assessment shall be valid for a period of not less than 12 months, unless a licensed Physician or licensed Psychologist determines an earlier assessment is necessary.

Treatment of Autism Spectrum Disorders shall be identified in an ASD Treatment Plan and shall include any Medically Necessary Pharmacy Care, Psychiatric Care, Psychological Care, Rehabilitative Care and Therapeutic Care that is: (1) prescribed, ordered or provided by a licensed Physician, licensed Physician assistant, licensed Psychologist, Licensed Clinical Social Worker or Certified Registered Nurse practitioner; (2) provided by an Autism Service Provider, including a Behavioral Specialist; or (3) provided by a person, entity or group that works under the direction of an Autism Service Provider.

An ASD Treatment Plan shall be developed by a licensed Physician or licensed Psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics. The ASD Treatment Plan may be reviewed by the Fund once every six months. A more or less frequent review can be agreed upon by the Fund and the licensed Physician or licensed Psychologist developing the ASD Treatment Plan.

Treatment of Autism Spectrum Disorders will include any of the following Medically Necessary services that are listed in an ASD Treatment Plan developed by a licensed Physician or licensed Psychologist:

- (1) *Applied Behavior Analysis*. The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
- (2) *Pharmacy Care*. Medications prescribed by a licensed Physician, licensed Physician assistant or Certified Registered Nurse practitioner and any assessment, evaluation or test prescribed or ordered by a licensed Physician, licensed Physician assistant or Certified Registered Nurse practitioner to determine the need or effectiveness of such medications.
- (3) *Psychiatric Care*. Direct or consultative services provided by a Physician who specializes in psychiatry.
- (4) *Psychological Care*. Direct or consultative services provided by a Psychologist.
- (5) *Rehabilitative Care*. Professional services and treatment programs, including applied behavioral analysis, provided by an Autism Service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.
- (6) *Therapeutic Care*. Services provided by speech language pathologists, occupational therapists or physical therapists.

The Plan does **not cover** the diagnosis and treatment of Autism Spectrum Disorders that is provided through a school as part of an individualized education program. In addition, the Plan does **not cover** the diagnosis and treatment of Autism Spectrum Disorders that is not included in the ASD Treatment Plan for Autism Spectrum Disorders.

(b) Autism-Related Definitions

- (1) *Autism Spectrum Disorders.* The term Autism Spectrum Disorders refers to any of the Pervasive Developmental Disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor. The term Pervasive Developmental Disorders refers to disorders characterized by severe and pervasive impairment in several areas of development, including: (A) reciprocal social interaction skills; (B) communication skills; or (C) the presence of stereotyped behavior, interests and activities. Examples include asperger’s syndrome and childhood disintegrative disorder.
- (2) *Autism Service Provider.* The term Autism Service Provider refers to a person, entity or group that provides treatment of Autism Spectrum Disorders (ASD), using an ASD Treatment Plan, and that is either licensed or certified in Pennsylvania or enrolled in Pennsylvania’s medical assistance program on or before the effective date of the Pennsylvania Autism Spectrum Disorders Law. An Autism Service Provider shall include a Behavioral Specialist.
- (3) *Autism Spectrum Disorders (ASD) Treatment Plan.* The term ASD Treatment Plan refers to a plan for the treatment of Autism Spectrum Disorders developed by a licensed Physician or licensed Psychologist who is a Professional Provider and based on a comprehensive evaluation or reevaluation, performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.
- (4) *Behavioral Specialist.* The term Behavioral Specialist refers to an individual with appropriate certification or licensure by the applicable state, who designs or implements or evaluates a behavior modification intervention component of an ASD Treatment Plan, through applied behavior analysis which includes: (A) skill acquisition and reduction of problematic behavior; (B) improvement in function and/or behavior significantly; or (C) prevention of loss of attained skill or function.

4.09 BLOOD

The Plan covers the administration of blood and blood processing from donors. In addition, the Plan covers:

- (a) *Autologous Blood Drawing, Storage or Transfusion.* This refers to a process that allows a Covered Person to have his or her own blood drawn and stored for personal use (for example, self-donation in advance of planned Surgery).
- (b) Whole blood, blood and blood derivatives which are not classified as drugs in official formularies and which have not been replaced by a donor.

4.10 COLORECTAL CANCER SCREENING

(a) In General

The Plan covers colorectal cancer screening for Symptomatic Covered Persons, Nonsymptomatic Covered Persons over age 50, and Nonsymptomatic Covered Persons under age 50 who are at high risk or increased risk for colorectal cancer. The provision of colorectal cancer screening must be in accordance with current American Cancer Society guidelines, and consistent with approved medical practices.

(b) Symptomatic Covered Persons

The term “Symptomatic Covered Person” refers to a Covered Person who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain. Coverage for Symptomatic Covered Persons includes a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screen tests at a frequency determined by a treating Physician.

(c) Nonsymptomatic Covered Persons

Coverage for Nonsymptomatic Covered Persons over age 50 includes, but is not limited to: (1) an annual fecal occult blood test; (2) a sigmoidoscopy, a screening barium enema, or a test consistent with approved medical standards and practices to detect colon cancer, at least once every five years; and (3) a colonoscopy at least once every ten years.

(d) Nonsymptomatic Covered Person at High or Increased Risk

A “Nonsymptomatic Covered Person under age 50 who is at high risk or increased risk” refers to a Covered Person who poses a higher than average risk for colorectal cancer according to the current American Cancer Society guidelines on screening for colorectal cancer. Coverage for Nonsymptomatic Covered Persons under age 50 who are at high risk or increased risk includes a colonoscopy and any combination of colorectal cancer screening tests.

4.11 DAY REHABILITATION PROGRAM

The term Day Rehabilitation Program refers to a level of Outpatient Care consisting of four to seven hours of daily rehabilitative therapies and other medical services five days per week. Under the program, the Covered Person returns home each evening and for the entire weekend. Therapies provided may include a combination of therapies, such as Physical Therapy, Occupational Therapy and Speech Therapy, and may include other medical services such as nursing services, psychological therapy and Case Management services.

The Plan covers Medically Necessary Day Rehabilitation Programs when provided by a Facility Provider under the following conditions: (a) the Covered Person must require intensive Therapy Services, such as Physical, Occupational and/or Speech Therapy 5 days per week for 4 to 7 hours per day; (b) the Covered Person must have the ability to communicate (verbally or non-verbally) their needs and must also have the ability to consistently follow directions and to manage their own behavior with minimal to moderate intervention by professional staff; (c) the Covered Person must be willing to participate in a Day Rehabilitation Program; and (d) the Covered Person’s family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

4.12 DIABETIC EDUCATION PROGRAM, EQUIPMENT & SUPPLIES

(a) Diabetic Education Program

When prescribed by a legally authorized Professional Provider, the Plan covers diabetes Outpatient self-management training and education, including medical nutrition, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes.

Outpatient diabetic education services must be provided by an In-Network Provider and be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Fund. The attending Physician must certify to the Fund that the Covered Person requires diabetic education on an Outpatient basis, under the following circumstances: (1) upon the initial diagnosis of diabetes; (2) upon a significant change in the Covered Person’s symptoms or condition; or (3) upon the introduction of new medication or a therapeutic process in the treatment or management of the Covered Person’s symptoms or condition.

Covered Services include Outpatient sessions that include, but may not be limited to, the following: (1) General facts/overview on diabetes; (2) initial assessment of the Covered Person’s needs; (3) nutrition, including its impact on blood glucose levels; (4) exercise and activity; (5) monitoring and use of the results of such monitoring; (6) psychological adjustment; (7) prevention and treatment of complications of chronic diabetes (that is, foot, skin and eye care); (8) pregnancy and gestational diabetes, if applicable; (9) use of community resources; and (10) family involvement and/or social support.

(b) Diabetic Equipment and Supplies

The Plan will cover diabetic equipment and supplies purchased from a Durable Medical Equipment Provider under the Plan's provisions regarding Durable Medical Equipment. Covered Diabetic Equipment includes: (1) blood glucose monitors; (2) insulin pumps; (3) insulin infusion devices; and (4) orthotics and podiatric appliances for the prevention of complications associated with diabetes. Covered Diabetic Supplies include: (1) blood testing strips; (2) lancets and lancet devices; (3) visual reading and urine test strips; (4) monitor supplies; (5) injection aids; (6) insulin syringes; and (7) glucagon emergency kits.

4.13 DIAGNOSTIC SERVICES

The Plan covers the following Diagnostic Services:

- (a) Routine Diagnostic Services, including: (1) routine radiology consisting of x-rays, ultrasound, and nuclear medicine; (2) routine medical procedures consisting of ECG, EEG, Nuclear Cardiology, Imaging and other diagnostic medical procedures approved by the Fund; and (3) allergy testing consisting of percutaneous, intracutaneous and patch tests.
- (a) Non-Routine Diagnostic Services, including: (1) MRI/MRA; (2) CT Scans; and (3) PET Scans.
- (c) Diagnostic laboratory and pathology tests.
- (d) Genetic testing and counseling, when the usefulness of such tests has been established by the Fund, are covered for the purposes of: (1) diagnosis; (2) screening; (3) examining risk for a disease; (4) predicting the course of a disease; (5) judging the response to a therapy; and (6) reproductive decision-making. Such tests may be appropriate for a Covered Person at risk for a specific disease that is the result of family history and exposure to environmental factors are known to cause physical or mental disorders.

4.14 DURABLE MEDICAL EQUIPMENT

(a) In General

The Plan covers the rental, or at the option of the Fund, the purchase of Durable Medical Equipment when prescribed by a Professional Provider and required for therapeutic use and determined to be Medically Necessary by the Fund.

(b) Replacement and Repair

The Plan covers the repair or replacement of Durable Medical Equipment when the equipment does not function properly and is no longer useful for its intended purchase, when a change in the Covered Person's condition requires a change in the Durable Medical Equipment, or when the Durable Medical Equipment is broken due to significant damage, defect, or wear so long as the equipment's warranty has expired and it has exceeded its reasonable useful life as determined by the Fund.

If the Durable Medical Equipment breaks while it is under warranty, replacement and repair is subject to the terms of the warranty. Contracts with the manufacturer or other responsible party to obtain replacement or repairs based on the warranty are the responsibility of the Claims Administrator in the case of rented equipment and the Covered Person in the case of purchased equipment. However, the Fund will not be responsible if the Durable Medical Equipment breaks during its reasonable useful lifetime for any reason not covered by warranty. For example, the Plan does **not cover** repairs and replacements needed because the equipment was abused or misplaced.

The Plan covers the repair of Durable Medical Equipment when the cost of repair is less than the cost to replace it. For purposes of this section, replacement means the removal and substitution of Durable Medical Equipment or one of its components necessary for proper functioning. Repair is a restoration of the Durable Medical Equipment or one of its components to correct problems due to wear or damage or defect.

(c) Definition of Durable Medical Equipment (DME)

Durable Medical Equipment refers to equipment that meets the following criteria: (1) it is an item that can withstand repeated use (“durable”); (2) it is equipment that is primarily and customarily used for medical purposes, and is not generally used in the absence of illness/injury (“medical equipment”); (3) it is generally not useful to a person without an illness/injury; and (4) it is appropriate for use in the home.

Durable Medical Equipment includes, but is not limited to: (1) diabetic supplies; (2) canes; (3) crutches; (4) walkers; (5) commode chairs; (6) home oxygen equipment; (7) Hospital beds; (8) traction equipment; and (9) wheelchairs.

(d) Exclusions

The Plan does **not cover** equipment that does not meet the definition of Durable Medical Equipment. Examples of equipment that do not meet the definition of Durable Medical Equipment include, but are not limited to:

- (1) Comfort and convenience items, such as massage devices, portable whirlpool pumps, telephone alert systems, bed-wetting alarms, and ramps.
- (2) Equipment used for environmental control, such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plans.
- (3) Equipment inappropriate for home use and generally requires professional supervision for proper operation, such as: (A) diathermy machines; (B) medcolator; (C) data transmission devices used for telemedicine purposes; (D) pulse tachometer; (E) translift chairs; and (F) traction units.
- (4) Non-reusable supplies other than a supply that is an integral part of the Durable Medical Equipment item and is required for the Durable Medical Equipment to function. This means the equipment is not durable or is not a component of the Durable Medical Equipment. Items not covered include, but are not limited to: (A) incontinence pads; (B) lamb’s wool pads; (C) ace bandage; (D) catheters (non-urinary); (E) face masks (surgical); (F) disposable gloves; (G) disposable sheets and bags; and (H) irrigating kits.
- (5) Equipment that is not primarily medical in nature. Equipment which is primarily and customarily used for a non-medical purpose may or may not be considered “medical” in nature. This is true even though the item may have some medically related use. Such items include, but are not limited to: (A) ear plugs; (B) exercise equipment; (C) ice packs; (D) speech teaching machines; (E) strollers; (F) feeding chairs; (G) silverware/utensils; (H) toileting systems; (I) electronically-controlled heating and cooling units for pain relief; (J) toilet seats; (K) bathtub lifts; (L) stair glides; (M) elevators; and (N) Equipment for Safety. The term Equipment for Safety refers to items which are primarily used to prevent injury or provide a safe surrounding, and are not primarily used for the diagnosis, care or treatment of a disease or injury.
- (6) Equipment with features of a medical nature which are not required by the Covered Person’s condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its costs, if there exists a Medical Necessity and realistically feasible alternative item that serves essentially the same purpose.
- (7) Duplicate equipment for use when traveling or for an additional residence, whether or not prescribed by a Professional Provider.
- (8) Services not primarily billed for by a Provider such as delivery, set-up and services activities and installation and labor of rented or purchased equipment.

- (9) Modifications to vehicles, dwellings and other structures. This includes any modifications made to a vehicle, dwelling or other structure to accommodate a Covered Person's disability or any modifications made to a vehicle, dwelling or other structure to accommodate a Durable Medical Equipment item, such as customization to a wheelchair.

4.15 EMERGENCY CARE SERVICES

The Plan covers Emergency Care Services at the In-Network level of benefits, regardless of whether the Covered Person is treated by an In-Network or Out-of-Network Provider. The term Emergency Care refers to Covered Services and supplies provided to a Covered Persons in, or for, an Emergency. The term Emergency refers to a sudden an unexpected onset of a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or 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: (a) placing the Covered Person's health, or in the case of a pregnant Covered Person, the health of the unborn child, in jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Payment for Out-of-Network Emergency Care Services will be the greater of: (a) the median of the amounts paid to In-Network Providers for Emergency Services; (b) the amount paid to Out-of-Network Providers; or (c) the amount paid by Medicare.

4.16 HOME HEALTH CARE

(a) In General

The Plan covers the following services when rendered by a Home Health Care Provider: (1) professional services of appropriately licensed and certified individuals; (2) intermittent skilled nursing care; (3) Physical Therapy; (4) Speech Therapy; (5) well mother/well baby care following release from an Inpatient maternity stay; and (6) care within 48 hours following release from an Inpatient Admission when the discharge occurs within 48 hours following a mastectomy. The Plan also covers certain other medical services and supplies, when provided along with a primary service, such as: (1) Occupational Therapy; (2) medical social services; and (3) home health aides in conjunction with skilled services and other services which may be approved by the Fund. There is no requirement that the Covered Person be previously confined to a Hospital or Skilled Nursing Facility prior to receiving Home Health Care.

With respect to well mother/well baby care following early release from an Inpatient maternity stay, Home Health Care services must be provided within 48 hours if: (1) discharge occurs earlier than 48 hours of a vaginal delivery; or (2) discharge occurs earlier than 96 hours of a cesarean delivery. No cost-sharing shall apply to these benefits when they are provided after an early discharge from the Inpatient maternity stay.

Home Health Care benefits will be provided only when prescribed by the Covered Person's attending Physician, in a written Plan of Treatment and approved by the Fund as Medically Necessary. With the exception of Home Health Care provided to a Covered Person immediately following an Inpatient release for maternity care, the Covered Person must be Homebound in order to be eligible to receive Home Health Care benefits by a Home Health Care Provider.

(b) Excluded Home Health Care Services

This Section excludes home health care services and supplies described as follows:

- (1) Custodial services, food, housing, housemaker services, Home delivered meals and supplementary dietary assistance.
- (2) Rental or purchase of Durable Medical Equipment.

- (3) Rental or purchase of medical appliances (for example, braces), Prosthetic Devices (for example, artificial limbs), and supportive environmental materials/equipment, such as: (A) handrails; (B) ramps; (C) telephones; (D) air conditioners and similar services; and (E) appliances and devices.
- (4) Prescription drugs.
- (5) Care rendered by family members, relatives and friends.
- (6) A Covered Person's transportation, including services provided by voluntary ambulance associations for which the Covered Person is not obligated to pay.
- (7) Emergency or non-Emergency Ambulance services.
- (8) Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services.
- (9) Services provided to individuals (other than a Covered Person released from an Inpatient maternity stay), who are not essentially Homebound for medical reasons; and
- (10) Visits by any Provider personnel solely for the purpose of assessing a Covered Person's condition and determining whether or not the Covered Person requires and qualifies for home health care services and will or will not be provided services by the Provider.

(c) Home Health Care Definitions

- (1) *Home.* For purposes of this Section, the term Home refers to where the Covered Person lives, such as a private residence/domicile, assisted living facility, long-term care facility, or Skilled Nursing Facility at a custodial level of care.
- (2) *Homebound.* A Covered Person will be considered Homebound if the Covered Person is unable to safely leave Home due to severe restrictions on the Covered Person's mobility. A Covered Person can be considered Homebound when leaving Home would involve considerable effort by the Covered Person and the Covered Person is unable to use transportation, without another's assistance. Children, unlicensed drivers, and individuals who cannot drive are not automatically considered Homebound.
- (3) *Home Health Care Provider.* The term Home Health Care provider refers to a Facility Provider, approved by the Fund, that is engaged in providing, either directly or through an arrangement, health care services to Covered Persons on an intermittent basis in the Covered Person's home in accordance with an approved home health care Plan of Treatment.

4.17 HOSPICE SERVICES

(a) In General

The Plan covers palliative and supportive services and respite care provided to a terminally ill Covered Person through a Hospice program offered by a Hospice Provider. Hospice Care is intended to make the Covered Person as comfortable and pain-free as possible.

A Covered Person is eligible for Hospice benefits if the Covered Person's attending Physician certifies that the Covered Person has a terminal illness, with a medical prognosis of six months or less, and the Covered Person elects to receive care primarily to relieve pain. Upon electing Hospice care, benefits for treatment provided to cure the terminal illness are no longer provided. However, the Covered Person may change their mind and elect not to receive Hospice care after electing to receive it.

If the Covered Person were to receive Hospice care primarily in the home, the Covered Person's primary caregiver may need to be relieved, for a short period. In such a case, the Plan will provide coverage for the

Covered Person to receive the same kind of care on a short-term basis, as an Inpatient, and in a Medicare certified Skilled Nursing Facility. However, this can only be arranged when the Hospice Provider considers such care necessary to relieve primary caregivers in the Covered Person's Home.

(b) Excluded Services

The Plan does **not cover** Hospice benefits for the following: (1) services and supplies for which there is no charge; (2) research studies directed to life lengthening methods of treatment; (2) services or expenses incurred in regard to the Covered Person's personal, legal and financial affairs, such as preparation and execution of a will or disposition of personal and real property; (3) care provided by family members, relatives, and friends; and (4) Private Duty Nursing.

(c) Hospice Definition

The term Hospice refers to a Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals. The Hospice must be certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency. The Hospice must also be appropriately licensed in the state where it is located.

4.18 HOSPITAL SERVICES

(a) Ancillary Services

The Plan covers all ancillary services usually provided and billed for by Hospitals, except for personal convenience items. This includes, but is not limited to: (1) meals, including special meals or dietary services, as required by the Covered Person's condition; (2) use of operating room, delivery room, recovery room, or other specialty service rooms and any equipment or supplies in those rooms; (3) casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body; (4) oxygen and oxygen therapy; (5) anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment; (6) Therapy Services, when administered by a person who is appropriately licensed and authorized to perform such services; (7) all drugs and medications (including intravenous injections and solutions) for use while in the Hospital, which are released for general use, and which are commercially available to Hospitals; (8) use of special care units, including, but not limited to intensive care units or coronary care units; and (9) preadmission testing.

(b) Room and Board

The Plan covers general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following: (1) an average semi-private room, as designated by the Hospital; (2) a private room, when designated by the Plan as semi-private for purposes of the Plan in Hospitals having primarily private rooms; (3) a private room, when Medically Necessary; (4) a special care unit, such as intensive or coronary care, when such designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient; (5) a bed in a general ward; and (6) nursery facilities.

(c) Limitations

The Plan limits Out-of-Network Hospital benefits to 70 inpatient days per calendar. This maximum is combined for all Out-of-Network Inpatient Hospital services, mental health/psychiatric care and treatment for Alcohol or Drug Abuse and Dependency. In computing the number of days of benefits, the Fund will count the day of the Covered Person's admission, but not the day of the Covered Person's discharge. Additionally, if the Covered Person is admitted and discharged on the same day, it will be counted as one day.

The Plan will only provide coverage for days spent during an uninterrupted stay in the Hospital. It will not provide coverage for: (1) time spent outside of the Hospital, if the Covered Person interrupts the stay and then stays past midnight on the day the interruption occurs; or (2) time spent in the Hospital after the discharge hour that the Covered Person's Physician has recommended that further Inpatient care is not required.

4.19 IMMUNIZATIONS

The Plan covers pediatric immunizations, adult immunizations, and the agents used for the immunizations. All immunizations, and the agents used for them, must conform to the standards set by the *Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, U.S. Department of Health and Human Services*. Pediatric and adult immunization ACIP schedules may be found by accessing the following link: <http://www.cdc.gov/vaccines/schedules/index.html>. Benefits for pediatric immunizations are limited to Covered Persons under 21 years of age.

4.20 INJECTABLE MEDICATIONS / SPECIALTY DRUGS

The Plan covers Standard Injectable Drugs and Specialty Drugs administered by a Professional Provider when required to treat an injury or illness as follows:

(a) Standard Injectable Drugs

The Plan covers drugs that are either injectable or infusible, such as allergy injections and extractions, antibiotics, and steroid injections. Drugs that qualify as Specialty Drugs are not covered under this subsection.

(b) Specialty Drugs

The Plan covers Specialty Drugs. The term Specialty Drug refers to a medication that meets certain criteria including, but not limited to: (1) the drug is used in the treatment of a rare, complex, or chronic disease; (2) a high level of involvement is required by a healthcare provider to administer the drug; (3) complex storage and/or shipping requirements are necessary to maintain the drug's stability; (4) the drug requires comprehensive patient monitoring and education by a healthcare provider regarding safety, side effects, and compliance; and (5) access to the drug may be limited. A list of Specialty Drugs is available at www.ibx.com.

The Copayment and Coinsurance amounts applicable to Specialty Drugs in the Schedule of Benefits apply: (1) to each 30-day supply of medication dispensed for medications administered on a regularly scheduled basis; or (2) to each course/series of injections if administered on an intermittent basis. A 90-day supply of medication may be dispensed for some medications that are used for the treatment of a chronic illness. In such case, the Covered Person will be subject to three Copayments, if applicable. The Claims Administrator reserves the right to determine which Specialty Drug vendors and/or Professional Providers can dispense or administer certain Specialty Drugs.

4.21 INSULIN AND ORAL AGENTS

The Plan covers Insulin and oral agents to control blood sugar as prescribed by a Physician and dispensed by a licensed pharmacy. Benefits are available for up to a 30 day supply when dispensed from a retail pharmacy.

4.22 MATERNITY/OBGYN/FAMILY SERVICES

(a) Artificial Insemination

The Plan covers services performed by a Professional Provider for the promotion of fertilization of a female recipient's own eggs by the introduction of mature sperm from a partner or donor into the recipient's vagina or uterus, with accompanying simple sperm preparation, sperm washing, and/or thawing.

(b) Elective Abortions

The Plan covers the voluntary termination of a pregnancy performed by a Professional Provider. The Plan also covers related services rendered in a Facility Provider that is a Hospital or Birth Center.

(c) Maternity/ Obstetrical Care

The Plan covers services rendered in the care and management of a pregnancy. Specifically:

- *Services.* The Plan covers Facility Services provided by a Professional Provider or certified nurse midwife. The Plan also covers professional services performed by a Professional Provider or certified nurse midwife.
- *Scope of Care.* The Plan covers prenatal care and postnatal care.
- *Type of Delivery / Early Discharge.* The Plan provides Inpatient benefits for 48 hours for vaginal deliveries and 96 hours for cesarean deliveries. In the event of early post-partum discharge from an Inpatient Admission, benefits are provide for Home Health Care, as previously set forth in this Plan.
- *Prenotification.* The Plan should be notified of the need for maternity care within one month of the first prenatal visit to your Physician or midwife.
- *Newborn Care.* The Plan provides benefits to newborn children under this Section from the date of birth up to a maximum of 31 days. Such coverage within the 31 days will include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity, and routine nursery care.

(d) Assisted Fertilization Techniques Not Covered

The Plan does **not cover** assisted fertilization techniques such as, but not limited to, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT).

(e) Treatment for Sexual Dysfunction Not Covered

This Section does **not cover** services and supplies provided to treat sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury.

4.23 MEDICAL CARE

The Plan covers Medical Care rendered: (a) by a Professional Provider who is in charge of the case; (b) during an Inpatient stay in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility; and (c) for a condition not related to Surgery, pregnancy, radiation therapy, or Mental Illness. Such care includes Inpatient intensive Medical Care rendered while the condition requires a Professional Provider’s constant attendance and treatment and for a prolonged period of time.

The Plan also covers the following Inpatient services, when they occur together: (a) Services rendered by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions; and (b) Inpatient services rendered in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility. However, these services do not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations, Medical Care routinely performed in the pre- or post-operative or pre- or post-natal periods, or Medical Care required by a Facility Provider’s rules and regulations.

The Plan also covers consultation services when rendered in both of the following ways: (a) by a Professional Provider, at the request of the attending Professional Provider; and (b) while the Covered Person is an Inpatient in a Hospital, Rehabilitation Hospital, or Skilled Nursing Facility. Benefits are limited to one consultation per consultant during any one Inpatient confinement. Consultations do not include staff consultations which are required by the Facility Provider’s rules and regulations.

4.24 MEDICAL FOODS AND NUTRITIONAL FORMULAS

The Plan covers Medical Foods when provided for the therapeutic treatment of inherited errors of metabolism (IEMs) such as Phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. Coverage is provided when administered on an Outpatient basis, either orally or through a tube. The term Medical Foods refers to liquid nutritional products which are specifically formulated to treat one of the above-referenced IEMs.

The Claims Administrator will provide coverage for Nutritional Formulas when the Nutritional Formula is the sole source of nutrition (more than 75% of estimated basal caloric requirement) for an infant or child suffering from Severe Systemic Protein Allergy, that does not respond to treatment with standard milk or soy protein formulas or casein hydrolyzed formulas. The term Nutritional Formula refers to liquid nutritional products which are formulated to supplement or replace normal food products. The term Severe Systemic Protein Allergy refers to allergic symptoms to ingested proteins of sufficient magnitude to cause weight loss or failure to gain weight, skin rash, respiratory symptoms, and gastrointestinal symptoms of significant magnitude to cause gastrointestinal bleeding and vomiting.

Benefits for Medical Foods and Nutritional Formulas are not subject to the Plan's Deductibles.

The Plan covers Medical Foods and Nutritional Formulas as described in this Section when provided through a Durable Medical Equipment supplier or in connection with Infusion Therapy as provided by the Plan. An estimated basal caloric requirement for Medical Foods and Nutritional Formulas is not required for IEMs.

The Plan does **not cover** amino acid supplements, non-elemental formulas, appetite suppressants or nutritional supplements. This exclusion includes basic milk, soy, or casein hydrolyzed formulas (for example, nutramigen, alimentum, pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy.

4.25 MENTAL HEALTH / PSYCHIATRIC CARE

(a) In General

The Plan covers the treatment of Mental Illness and Serious Mental Illness based on the services provided and reported by the Provider in accordance with the Plan's Schedule of Benefits.

(b) Mental Illness and Serious Mental Illness

The term Mental Illness is defined as any of various conditions, wherein mental treatment is provided by a qualified mental health Provider, which are categorized as mental disorders by the most current edition of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM).

The term Serious Mental Illness means any of the following biologically based Mental Illnesses, as defined by the American Psychiatric Association, in the most current edition of the ICD or DSM: (1) schizophrenia; (2) bipolar disorder; (3) obsessive-compulsive disorder; (4) major depressive disorder; (5) panic disorder; (6) anorexia nervosa; (7) bulimia nervosa; (8) schizo-affective disorder; (9) delusional disorder; and (10) any other Mental Illness that is considered to be a "Serious Mental Illness" by law.

(c) Examples of Covered Services

Covered Inpatient services include treatments such as psychiatric visits, psychiatric consultations, individual and group psychotherapy, electroconvulsive therapy, psychological testing, and psychopharmacological management. Covered Outpatient services include treatments covered on an Inpatient basis, as well as Licensed Clinical Social Worker visits, psychoanalysis, and Masters Prepared Therapist visits.

The term Licensed Clinical Social Worker refers to a social worker who has graduated from a school accredited by the Council on Social Work Education with a Doctoral or Master's Degree and is licensed by the appropriate state authority.

The term Masters Prepared Therapist refers to a therapist who holds a Master's Degree in an acceptable human services-related field of study, is licensed as a therapist at an independent practice level, and is licensed by the appropriate state authority to provide therapeutic services for the treatment of Mental Illness and Serious Mental Illness.

(d) Excluded Services

The Plan does **not cover**: (1) vocational or religious counseling; (2) activities that are primarily of an educational nature; and (3) treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as primal therapy, rolfing or structural integration, bioenergetic therapy, and obesity control therapy.

4.26 NON-SURGICAL DENTAL SERVICES

(a) In General

The Plan covers the initial treatment of fractured facial bones and fractured jaws in order to restore proper function. Restoration of proper function includes the dental services required for initial restoration or replacement of Sound Natural Teeth, required for the initial treatment for an Accidental Injury/trauma. This includes the first caps, crowns, and dentures (but not dental implants). This also includes the preparation of the jaws and gums required for initial replacement Sound Natural Teeth.

The term Sound Natural Teeth refers to teeth that are stable, functional, free from decay and advanced periodontal disease, in good repair at the time of the Accidental Injury/trauma, and are not man-made.

(b) Excluded Dental Services Under the Medical Benefit Provisions of the Plan

This Section does **not cover** dental services related to:

- (1) The care, filling, removal or replacement of teeth, including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasia or dentinogenesis imperfecta.
- (2) The treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in the Plan.
- (3) The following: (A) apicoectomy (dental root resection); (B) prophylaxis of any kind; (C) root canal treatments; (D) soft tissue impactions; (E) alveolectomy; (F) bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and (G) treatment of periodontal disease.
- (4) Dental implants.
- (5) Dentures, unless for the initial treatment of an Accidental Injury/trauma.
- (6) Orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate.
- (7) Injury as a result of chewing or biting (neither is considered an Accidental Injury).

4.27 NUTRITION COUNSELING FOR WEIGHT MANAGEMENT

The Plan covers nutrition counseling visits or sessions for the purpose of weight management. However, they need to be performed and billed by any of the following Providers, in an office setting: (a) by the Covered Person's Physician; (b) by a Specialist; or (c) by a Registered Dietitian (RD). The term Registered Dietitian refers to a dietitian

registered by a nationally recognized professional organization of dietitians, who is a food and nutrition expert, and who has met the minimum academic and professional requirements to qualify for the credential RD.

4.28 ORTHOTICS

The term orthotics refers to devices used for the support of bones and joints. The Plan covers the initial purchase and fitting (per medical episode) of orthotic devices which are Medically Necessary as determined by the Fund. The Plan also covers the replacement of covered orthotics for Eligible Dependent children when required due to natural growth.

The Plan does **not cover** foot orthotics, unless the Covered Person requires foot orthotics as a result of diabetes. Examples of foot orthotics the Plan does **not cover** include, but are not limited to, foot inserts, arch supports, heel pads and heel cups, and orthopedic/corrective shoes.

4.29 PODIATRIC CARE

The Plan covers treatment for capsular or surgical treatment of bunions, ingrown toenail Surgery, and other non-routine Medically Necessary foot care. In addition, for Covered Persons with peripheral vascular and/or peripheral neuropathic diseases, including but not limited to diabetes, benefits for routine foot care services are covered.

Unless they are associated with the Medically Necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease (including, but not limited to, diabetes), the Plan does **not cover** foot care intended to make the foot feel better or look better, including treatment for: (1) bunions—except capsular or bone Surgery; (2) toenails—Surgery for ingrown nails; (3) subluxations of the foot; (4) corns; (5) calluses; (6) fallen arches; (7) weak feet; (8) chronic foot strain; (9) pes planus (i.e., flat fee); or (10) other routine podiatry care.

4.30 PREVENTIVE CARE

(a) Adult Preventive Care

The Plan covers the following types of adult preventive care services:

- (1) *Physical Examination, Routine History*. Well person care, which generally includes a medical history, height and weight measurement, physical examination and counseling, plus necessary Diagnostic Services, is limited to Covered Persons 18 years of age or older in accordance with the following schedule: (A) one examination every Plan Year at 18, 19, 20, and 21 years of age; (B) one examination every two Plan Years between 22 and 39 years of age; and (C) one examination every Plan Year, beginning at 40 years of age.
- (2) *Blood Cholesterol Test*. This blood test measures the total serum cholesterol level. High blood cholesterol is one of the risk factors that lead to coronary artery disease. This service is limited to one test every four Plan Years between 18 and 39 years of age, and one examination every Plan Year beginning at 40 years of age.
- (3) *Complete Blood Count (CBC)*. This blood test checks the red and white blood cell levels, hemoglobin and hematocrit. This service is limited to: (A) one test every Plan Year at 18, 19, 20, and 21 years of age; (B) one examination every two Plan Years between 22 and 39 years of age; and (C) one test every Plan Year beginning at 40 years of age.
- (4) *Fecal Occult Blood Test*. This test checks for the presence of blood in the feces. Blood in the feces is an early sign of colorectal cancer. This service is limited to one test every Plan Year, beginning at 50 years of age.
- (5) *Flexible Sigmoidoscopy*. This test detects colorectal cancer by use of a flexible fiberoptic sigmoidoscope. This test is limited to one test every three Plan Years, beginning at 50 years of age.

- (6) *Prostate Specific Antigen (PSA)*. This blood test may be used to detect tumors of the prostate. This service is limited to one test every Plan Year, beginning at 50 years of age.
- (7) *Routine Colonoscopy*. This test detects colorectal cancer by use of a flexible device called a fiberoptic colonoscope. This service is limited to one test every ten Plan Years, beginning at 50 years of age.
- (8) *Rubella Titer Test*. The rubella titer blood test checks for the presence of rubella antibodies.
- (9) *Thyroid Function Test*. This test detects hyperthyroidism and hypothyroidism. This service is limited to one series of tests every Plan Year, beginning at 18 years of age.
- (10) *Urinalysis*. This test detects numerous abnormalities. This service is limited to one test every Plan Year, beginning at 18 years of age.
- (11) *Fasting Blood Glucose Test*. This test is used to detect diabetes. This service is limited to one test every three years, beginning at age 45.
- (12) *Abdominal Aortic Aneurysm Screening*. One test per lifetime is recommended for men with a smoking history. This service is limited to one ultrasound for men between 65 and 75 years of age.

(b) Pediatric Preventive Care

The Plan covers the following types of pediatric preventive care services:

- (1) *Physical Examination, Routine History, Routine Diagnostic Tests*. Well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling, is limited to Covered Persons under 18 years of age in accordance with this subsection. When a range is given as follows (that is, 2-3 months), the dash indicates that coverage is available for one service from two months through three months of age. 26 total examinations are available up to age 17, according to each of the following age groups:
 - Eleven exams between ages of 0-30 months within the following age ranges:

3-5 days	6-8 months	18-23 months
0-1 month	9-11 months	24-29 months
2-3 months	12-14 months	30 months
4-5 months	15-17 months	
 - One exam every Plan Year between three and 17 years of age.
- (2) *Blood Lead Screening*. This blood test detects elevated lead levels in the blood. Children are covered for one test between 9-12 months of age and one test at 24 months of age.
- (3) *Hemoglobin/Hematocrit*. This blood test measures the size, shape, number and content of red blood cells. Children are covered for: (A) one test between 0-12 months of age; (B) one test between 1 and 4 years of age; (C) one test between 5 and 12 years of age; and (D) one test between 13 and 17 years of age.
- (4) *Rubella Titer Test*. The rubella titer blood test checks for the presence of rubella antibodies.
- (5) *Urinalysis*. This test detects numerous abnormalities. Children are covered for one test every 365 days between 0-24 months of age and one test every Plan Year between 2 and 17 years of age.

(c) Women’s Preventive Care

The Plan covers services and supplies as described in the women’s preventive care services provision of PPACA. Covered Services and supplies include, but are not limited to, the following:

- (1) *Routine Gynecological Exam.* Female Covered Persons are covered for one routine gynecological exam each Plan Year. The exam shall include a pelvic exam, clinical breast exam, and routine pap smears, and must be performed in accordance with the recommendations of the American College of Obstetricians and Gynecologists.
- (2) *Mammograms.* Female Covered Persons are covered for screening and diagnostic mammograms. The Fund will only provide coverage for benefits for mammography if the following applies: (A) it is performed by a qualified mammography service provider; (B) that service provider is properly certified by the appropriate state or federal agency; and (C) that certification is done in accordance with the Mammography Quality Assurance Act of 1992.
- (3) *Breastfeeding Support & Counseling.* Female Covered Persons are covered for comprehensive breastfeeding support and counseling from trained providers, access to breastfeeding supplies (including coverage for rental of hospital-grade breastfeeding pumps under Durable Medical Equipment supplier with Medical Necessity review), lactation support and counseling provided during postpartum hospitalization, mother’s option visits, and obstetrician or pediatrician visits for pregnant and nursing women at no cost share to the Covered Person when provided by an In-Network Provider.
- (4) *Contraception.* Female Covered Persons are covered for Food and Drug Administration-approved contraceptive methods (including contraceptive drugs and devices, injectable contraceptives, IUDs and implants,) sterilization procedures, and patient education and counseling, not including abortifacient drugs, at no cost to the Covered Person at retail and mail order for generic products and for those methods that do not have a generic equivalent when provided by an In-Network Provider.

(d) Osteoporosis Screening (Bone Mineral Density Testing or BMDT)

The Plan covers Bone Mineral Density Testing (BMDT). The method used needs to be one that is approved by the U.S. Food and Drug Administration. This test determines the amount of mineral in a specific area of the bone. It is used to measure bone strength, which depends on both bone density and bone quality. Bone quality refers to how the bone is built, architecture, turnover and mineralization of bone. A BMDT must be prescribed by a Professional Provider legally authorized to prescribe such testing. This service is limited to one screening every two Plan Years beginning at age 65.

4.31 PRIMARY CARE PHYSICIAN OFFICE & RETAIL CLINIC VISITS

The Plan covers Medical Care visits, by a Primary Care Provider, to examine, diagnose, or treat an illness or injury. The term “visits” refers to visits to a Provider’s office, visits by a Provider to a Covered Person’s residence, or consultations by a Provider on an Outpatient basis. The term Primary Care Provider refers to a Professional Provider listed in the Personal Choice Network directory under “Primary Physicians” (General Practice, Family Practice, or Internal Medicine), “Obstetricians /Gynecologists” or “Pediatricians”. The term Primary Care Services includes routine Medical Care traditionally provided to individuals with common illness, injuries, and chronic illnesses.

The Plan also covers Medical Care rendered at a Retail Clinic. Retail Clinics are staffed by certified family nurse practitioners, who are trained to diagnose, treat, and write prescriptions when clinically appropriate. Nurse practitioners are supported by a local Physician who is on-call during clinic hours to provide guidance and direction when necessary. Examples of treatment and services that are provided at a Retail Clinic include, but are not limited to: (a) sore throat; (b) ear, eye or sinus infection; (c) allergies; (d) minor burns; (e) skin infections or rashes; (f) pregnancy testing; and (g) Urgent Care.

4.32 PRIVATE DUTY NURSING SERVICES

The Plan covers Private Duty Nursing when ordered by a Physician. Private Duty Nursing is defined as Medically Necessary, complex skilled nursing care provided in the Covered Person's private residence when performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN). It provides continuous monitoring and observation of a Covered Person who requires frequent skilled nursing care on an hourly basis.

The term Licensed Registered Nurse refers to a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by the appropriate state authority. The term Licensed Practical Nurse refers to a nurse who has graduated from a formal practical or nursing education program and is licensed by the appropriate state authority.

The Plan does **not cover** Private Duty Nursing services in connection with the following: (a) nursing care which is primarily custodial in nature, such as care that primarily consists of bathing, feeding, exercising, homemaking, moving the patient and giving oral medication; (b) services provided by a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's Immediate Family; and (c) services provided by a home health aide or nurse's aide. The Plan also does **not cover** Inpatient Private Duty Nursing services.

4.33 PROSTHETIC DEVICES

The Plan covers expenses Incurred for Prosthetic Devices required as a result of illness or injury. The term Prosthetic Device refers to a device (except dental Prosthetics) which replace all or part of an absent body organ (including contiguous tissue), or the function of a permanently inoperative or malfunctioning body organ. Expenses for Prosthetic Devices are subject to medical review by the Fund to determine eligibility and Medical Necessity. Covered Expenses, may include, but not be limited to:

- (a) The purchase, fitting, necessary adjustments and repairs of the Prosthetic Device.
- (b) The supplies and replacement of parts necessary for the proper functioning of the Prosthetic Device.
- (c) Breast prostheses required to replace the removed breast or portions thereof as a result of mastectomy and prostheses inserted during reconstructive Surgery incident and subsequent to the mastectomy.
- (d) Benefits are provided for the following visual Prosthetics when Medically Necessary and prescribed for one of the following conditions:
 - (1) Initial contact lenses prescribed for treatment of infantile glaucoma.
 - (2) Initial pinhole glasses prescribed for use after Surgery for detached retina.
 - (3) Initial corneal or scleral lenses prescribed in connection with the treatment of keratoconus or to reduce a corneal irregularity other than astigmatism.
 - (4) Initial scleral lenses prescribed to retain moisture in case where normal tearing is not present or adequate.
 - (5) Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of Accidental Injury, trauma, or ocular Surgery.

Benefits for replacement of a Prosthetic Device or its parts will be provided when there has been a significant change in the Covered Person's medical condition that requires the replacement, if the prostheses breaks because it is defective, if the prostheses breaks because it exceeds its life expectancy, as determined by the manufacturer, or for a Dependent child due to the normal growth process when Medically Necessary.

Benefits to repair Prosthetic Devices will be provided when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of the prostheses, replacement means the removal and substitution of the

prostheses or one of its components necessary for proper functioning. A repair is a restoration of the prostheses or one of its components to correct problems due to wear or damage.

The Plan does **not cover** repairs and replacements needed because the prostheses was abused or misplaced. Additionally, if a Prosthetic Device breaks and is under warranty, it is the responsibility of the Covered Person to work with the manufacturer to replace or repair it. Finally, the Plan does **not cover** cranial prostheses, including wigs intended to replace hair.

4.34 SKILLED NURSING FACILITY SERVICES

The Plan covers Skilled Nursing Facility Services when Medically Necessary, as determined by the Plan, so long as the Covered Person requires treatment by skilled nursing personnel which can only be provided on an Inpatient bases in a Skilled Nursing Facility.

The term Skilled Nursing Facility refers to an institution or a distinct part of an institution (other than one which is primarily for the care and treatment of Mental Illness, tuberculosis, or Alcohol Or Drug Abuse And Dependency) which, is accredited as a skilled nursing facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations, is certified as a skilled nursing facility or extended care facility under Medicare, or is otherwise acceptable to the Fund.

The Plan will only provide coverage for days spent during an uninterrupted stay. The Plan does **not cover**: (a) time spent outside of the Skilled Nursing Facility if the Covered Person interrupts his or her stay and then stays past midnight on the day the interruption occurs; (b) time spent in the Skilled Nursing Facility if the Covered Person remains past midnight on the day the interruption occurred; or (c) time spent in the Skilled Nursing Facility after the discharge hour that the Covered Person's attending Physician has recommended that further Inpatient care is not required. In computing the numbers of days of benefits, the Plan will count the day of the Covered Person's admission, but not the day of the Covered Person's discharge. The Plan also does **not cover** Skilled Nursing Facility services in connection with the following: (a) when confinement in a Skilled Nursing Facility is intended solely to assist the Covered Person with the activities of daily living or to provide an institutional environment for the convenience of the Covered Person; (b) for the treatment of Alcohol And Drug Abuse Or Dependency and Mental Illness; or (c) after the Covered Person has reached the maximum level of recovery possible for their particular condition and no longer requires definitive treatment other than routine Custodial Care.

4.35 SPECIALIST OFFICE VISITS

(a) In General

The Plan covers Specialist Services Medicare Care provided in the office of a Provider other than a Primary Care Provider. For purposes of this Section, "in the office" includes Medical Care visits to a Provider's office, Medical Care visits by a Provider to the Covered Person's residence, or Medicare Care consultations by a Provider on an Outpatient basis. The term Specialist Services refers to all Professional Provider services related to Medical Care or mental health/psychiatric care in any generally accepted medical or surgical specialty or subspecialty.

(b) Acupuncture

Acupuncture office visits are included as part of the Plan's overarching strategy to implement initiatives to fight the opioid epidemic and add more creative solutions for treatment. Acupuncture benefits are limited to 18 visits per year and limited to treat the following Medically Necessary diagnoses: (1) headache (migraine, tension); (2) post-operative and chemotherapy-induced nausea and vomiting; (3) nausea caused by pregnancy; (4) lower back pain; (5) pain resulting from osteoarthritis of the knee/hip; (6) chronic neck pain.

4.36 SPINAL MANIPULATION SERVICES

The Plan covers the detection and correction of structural imbalance or dislocation (subluxation) of the Covered Person's spine resulting from, or related to any of the following: (a) distortion of, or in, the vertebral column; (b) misalignment of, or in, the vertebral column; or (c) dislocation (subluxation) of, or in, the vertebral column. The detection and correction can be done by manual or mechanical means (by hand or machine).

4.37 SURGICAL SERVICES

(a) In General

The Plan covers surgical services provided by a Professional Provider and/or Facility Provider for the treatment of a disease or injury. The term Surgery refers to the performance of generally accepted operative and cutting procedures including specialized instruments, endoscopic examinations, and other invasive procedures. Treatment of burns, fractures and dislocations is also considered Surgery.

Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care. Separate payment will not be made for such care.

(b) Anesthesia

The Plan will cover the administration of Anesthesia in connection with the performance of Covered Services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider. However, this Section does **not cover** an Obstetrician providing Anesthesia during labor and delivery, or an oral surgeon providing services otherwise covered under the Plan.

(c) Assistant Surgeon

The Plan will provide coverage for an assistant surgeon's services if: (1) the assistant surgeon actively assists the operating surgeon in the performance of covered Surgery; (2) an intern, resident, or house staff member is not available; and (3) the Covered Person's condition or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Plan.

(d) Hospital Admission for Dental Procedures or Dental Surgery

The Plan will cover a Hospital admission in connection with dental procedures or dental Surgery only when the Covered Person has an existing non-dental physical disorder or condition and hospitalization is Medically Necessary to ensure the Covered Person's health. Dental procedures or dental Surgery performed during such a confinement will only be covered for the services described in the "Oral Surgery" and "Assistant at Surgery" provisions of this Section.

(e) Oral Surgery

The Plan will provide coverage for Covered Services rendered by a Professional Provider and/or Facility Provider for:

- (1) *Orthognathic Surgery*. Surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following indications only: (A) for the initial treatment of Accidental Injury/trauma (that is, fractured facial bones and fractured jaws), in order to restore proper function; (B) in cases where it is documented that a severe congenital defect (that is, cleft palate) results in speech difficulties that have not responded to non-surgical interventions; or (C) in cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic Surgery will decrease airway resistance, improve breathing, or restore swallowing.

- (2) *Other Oral Surgery.* Surgery on or involving the teeth, mouth, tongue, lips, gums, and contiguous structures. Covered services will only be provided for: (A) surgical removal of impacted teeth which are partially or completely covered by bone; (B) surgical treatment of cysts, infections, and tumors performed on the structure of the mouth; and (C) surgical removal of teeth prior to cardiac Surgery, Radiation Therapy or organ transplantation.
- (3) *Congenital Cleft Palate.* This Section covers the orthodontic treatment of congenital cleft palates that involve the maxillary arch (the part of the upper jaw that holds the teeth), that is performed together with bone graft Surgery, and that is performed to correct bony defects that are present with extremely wide clefts affecting the alveolus.

(f) Second Surgical Opinion (Voluntary)

The Plan covers consultations for Surgery to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is Surgery which is not of an Emergency or life threatening nature. Covered Services under this subsection must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery.

(g) Additional Covered Surgical Services

When performed after a mastectomy, the Plan will cover Surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to, augmentation, mammoplasty, reduction mammoplasty, or mastopexy.

Coverage is also provided for: (a) the Surgical procedure performed in connection with the initial and subsequent insertion or removal of Prosthetic Devices (either before or after Surgery) to replace the removed breast or portions of it; (b) the treatment of physical complications at all stages of the mastectomy, including lymphedemas; and (c) routine neonatal circumcisions and any voluntary surgical procedure for sterilization. However, the Plan does **not cover** any Surgery performed to reverse a sterilization procedure.

Treatment of lymphedemas is not subject to any benefit Maximum amounts that may apply to Physical Therapy services as provided under the Section entitled Therapy Services.

(h) Cosmetic Surgery Not Covered

The Plan does **not cover** Surgery which is performed to improve the appearance of any portion of the body and from which no improvement in physiological function can be expected. However, benefits are payable to correct a condition resulting from an accident and functional impairment which results from a covered disease, injury or congenital birth defect. Additionally, this exclusion for cosmetic Surgery does not apply to mastectomy-related charges covered by the Plan.

(i) Surgery Related to Obesity Generally Not Covered / One Surgery Per Lifetime If Medically Necessary

This Section does **not cover** surgical treatment for obesity, except when the Plan determines the Surgery is Medically Necessary, in which case surgical treatment for obesity is limited to one surgical procedure per lifetime. Any new or different obesity Surgery, and any revision, repeat, or reversal of any previous Surgery is **not covered**. However, this exclusion of coverage for a repeat, reversal or revision of a previous obesity surgery does not apply when the procedure results in technical failure or when the procedure is required to treat complications, which if left untreated, would result in endangering the health of the Covered Person.

4.38 THERAPY SERVICES

(a) In General

The Plan will cover the services described in the following subsections when prescribed by a Physician and performed by a Professional Provider, a therapist who is registered or licensed by the appropriate authority

to perform the applicable therapeutic services, and/or Facility Provider. Such services are used in the treatment of an illness or injury to promote recovery of the Covered Person.

(b) Cardiac Rehabilitation Therapy

The Plan covers medically supervised rehabilitation programs designed to improve a Covered Person's tolerance for physical activity or exercise.

(c) Chemotherapy

The Plan covers the treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics or other related biotech products. Such chemotherapeutic agents are eligible if administered intravenously or intramuscularly (through intra-arterial injection, infusion, perfusion or subcutaneous, intracavitary or oral routes). The cost of drugs, approved by the Federal Food and Drug Administration (FDA) and only for those uses for which such drugs have been specifically approved by the FDA as antineoplastic agents is covered, provided they are administered as described in this paragraph.

(d) Dialysis

The Plan covers the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body by hemodialysis, peritoneal dialysis, hemoperfusion, chronic ambulatory peritoneal dialysis (CAPD), or continuous cyclical peritoneal dialysis (CCPD).

(e) Infusion Therapy

The Plan covers the infusion of drug, hydration, or nutrition (parenteral or enteral) into the body by a Professional Provider. Infusion therapy includes all professional services, supplies and equipment that are required to safely and effectively administer the therapy. Infusion may be provided in a variety of settings (e.g., home, office, Outpatient) depending on the level of skill required to prepare the drug, administer the infusion, and monitor the Covered Person.

(f) Occupational Therapy

The Plan covers treatment concerned with improving or restoring neuromusculoskeletal (nerve, muscle, and bone) functions which have been impaired by illness or injury, birth defect, or prior therapeutic intervention. Such coverage includes the treatment of physically disabled persons by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. This subsection covers the services rendered by a registered, licensed occupational therapist. This subsection does **not cover** services specifically directed towards the improvement of vocational skill and social functioning.

(g) Orthoptic/Pleoptic Therapy

The Plan covers treatment through an evaluation and training session program for the correction of oculomotor dysfunction as a result of a vision disorder, eye Surgery, or injury resulting in the lack of vision depth perception.

(h) Physical Therapy

The Plan covers treatment of physical disabilities or impairments resulting from disease, injury, congenital anomaly, or prior therapeutic intervention. Such treatment may include treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part, including the treatment of functional loss following hand and/or foot Surgery.

(i) Pulmonary Rehabilitation Therapy

The Plan provides a multidisciplinary, comprehensive program for Covered Persons who have chronic lung disease, which combines Physical Therapy with an educational process designed to reduce symptoms of pulmonary diseases, improve functional status, and stabilize or reverse manifestations of the disease.

(j) Radiation Therapy

The Plan covers the treatment of disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery, including the cost of radioactive materials supplied and billed by the Provider.

(k) Speech Therapy

The Plan covers the diagnosis and treatment of speech and language disorders, including the correction of a speech impairment, due to conditions or events that result in communication disabilities and/or swallowing disorders, such as disease, Surgery, injury, congenital and developmental abnormalities (birth defects), or previous therapeutic processes. This subsection covers the services rendered by a speech therapist.

(l) Therapy Services / General Exclusions

(1) *Chronic Conditions.* The Plan does **not cover** the Maintenance of chronic conditions, injuries or illness. The Plan does **not cover** any Therapy Service provided for: (A) ongoing Outpatient treatment of chronic medical conditions that are not subject to significant functional improvement; (B) additional therapy beyond the Plan's limits, if any, as set forth in the Schedule of Benefits; (C) work hardening; (E) evaluations not associated with therapy; or (E) therapy for back pain in pregnancy without specific medical conditions.

The term Maintenance refers to a continuation of the Covered Person's care and management when the maximum therapeutic value of a Medically Necessary treatment plan has been achieved, no additional functional improvement is apparent or expected to occur, the provision of Covered Services for a condition ceases to be of therapeutic value, and it is no longer Medically Necessary. The term Maintenance includes services that seek to prevent disease, promote health and prolong and enhance the quality of life.

(2) *Cognitive Rehabilitation Therapy.* The Plan does **not cover** Cognitive Rehabilitation Therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupation and speech therapies in a multidisciplinary, goal-oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (for example: stroke, acute brain insult, encephalopathy).

Cognitive Rehabilitation Therapy is a medically prescribed, multidisciplinary approach that consists of tasks that establish new ways for a person to compensate for brain function that has been lost due to injury, trauma, stroke, or encephalopathy; or reinforce or re-establish previously learned patterns of behavior. It consists of a variety of therapy modalities which lessen and ease problems caused by deficits in attention, visual processing, language, memory, reasoning, and problem solving. It is performed by any of the following professionals, using a team approach: (A) a Physician; (B) a neuropsychologist; or (C) a Psychologist, as well as a physical, occupational or speech therapist.

4.39 TRANSPLANT SERVICES

(a) In General

The Plan covers Inpatient and Outpatient transplants of human organs, marrow or tissue, which are not Experimental/Investigational, and whereby a Covered Person is the recipient. The Plan also covers services rendered to the Covered Person which are directly and specifically related to the covered transplantation. This includes services for the examination of such transplanted organs, marrow, or tissue and the processing of Blood provided to a Covered Person.

(b) Coverage Rules

- (1) When both the recipient and donor are Covered Persons, each is entitled to the benefits described in this Section.
- (2) When only the recipient is a Covered Person, both the donor and the recipient are entitled to the benefits described in this Section. However, the donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, coverage under the Plan, or coverage under any government program. Benefits provided to the donor will be charged against the recipients coverage under the Plan.
- (3) When only the donor is a Covered Person, no benefits will be provided under this Section.
- (4) If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue.

4.40 URGENT CARE CENTERS

The Plan will provide coverage for Urgent Care Centers, when Medically Necessary as determined by the Plan. The term Urgent Care Center refers to a Facility Provider designed to offer immediate evaluation and treatment for sudden health conditions and Accidental Injuries that require medical attention in a non-Emergency situation and when the Covered Person’s Professional Provider’s office is unavailable.

The term Urgent Care refers to care for a sudden illness or Accidental Injury that requires prompt medical attention but is not life-threatening and is not an Emergency medical condition. Examples of Urgent Care include stitches, fractures, sprains, ear infections, sore throats, rashes, and x-rays that are not Preventive Care.

PART C – COST-MANAGEMENT RULES AND PROCESSES

Part C of this Chapter describes the Fund’s rules regarding when you must obtain Preapproval from the appropriate Claims Administrator to ensure that proposed services are Medically Necessary and covered by the Plan. Part C also describes the Fund’s utilization review process.

As previously noted, capitalized terms used in this Chapter and throughout the Plan have special meaning. In most cases, these terms are defined in Part D of this Chapter. However, where a term is specific to a particular type of covered benefit, the term is defined in the Section of the Plan that describes such benefit. Finally, you should also note that Chapter 5 describes what is excluded from coverage under the Plan.

As always, if you have any questions regarding the Plan or the manner in which the Fund operates, feel free to contact the Fund Office at (215) 856-9663.

4.41 PREAPPROVAL / PRECERTIFICATION

Precertification review evaluates the Medical Necessity of proposed services (including the setting where proposed services are to be rendered) for coverage under the Plan. Where Precertification review is required, the Plans coverage of a proposed procedure is contingent upon the review being completed and receipt of the approval certification.

If a proposed treatment is to be provided by an In-Network Provider, the Covered Person is not responsible for initiating the Precertification review process. In addition, if the In-Network Provider fails to obtain a required Precertification of services, the Covered Person will be held harmless from any associated financial penalties assessed as a result. When a Covered Person seeks treatment from an Out-of-Network Provider or a BlueCard PPO Provider (excluding Inpatient Admissions), the Covered Person is responsible for initiating the Precertification Process.

If a request for Precertification is denied, the Covered Person will be notified of such decision in writing. If the Covered Person elects to continue treatment or care that has not been approved, the Covered Person will be asked to acknowledge this in writing, request to have the services provided, and state his or her willingness to assume financial responsibility for such services.

*****All Inpatient Admissions, other than an Emergency or maternity admission, must be Precertified*****

*****Covered Persons are responsible for notifying the Claims Administrator of an Out-of-Network Provider Emergency admission within two business days of the admission, or as soon as reasonably possible, as determined by the Claims Administrator*****

*****IF A COVERED PERSON FAILS TO PRECERIFY WHEN REQUIRED WHEN USING AN OUT-OF-NETWORK PROVIDER OR A BLUE CARD PPO PROVIDER (OTHER THAN INPATIENT ADMISSIONS), THE COVERED PERSON WILL BE SUBJECT TO A 20% REDUCTION IN BENEFITS IF PRECERTIFICATION IS NOT OBTAINED*****

To obtain a list of services that require Precertification, please log on to www.ibxpress.com or call the customer service telephone number that is listed on the back of your ID card.

4.42 UTILIZATION REVIEW PROCESS

A basic condition of the Plan's coverage is that in order for a health care service to be covered or payable, the service must be Medically Necessary. To assist the Fund in making coverage determinations for requested health care services, the Claims Administrator uses established Independence Blue Cross Medical Policies and medical guidelines based on clinically credible evidence to determine the Medical Necessity of the requested services. The appropriateness of the requested setting in which the services are to be performed is part of this assessment. The process of determining the Medical Necessity of requested health care services for coverage determinations based on benefits available under the Plan is called utilization review.

Where the review is required *before* a service is performed, the utilization review process is referred to as Precertification. The Plan's provisions regarding Precertification are described in the previous Section.

PART D –DEFINITIONS

Part D of this Chapter includes definitions in addition to those listed in Chapter 1 along with a listing of the types of providers covered under the medical provisions of this Plan.

4.43 DEFINITIONS

(a) Accidental Injury

Injury to the body that is solely caused by an accident, and not by any other causes.

(b) Anesthesia

The process of giving the Covered Person an approved drug or agent, in order to: (1) cause the Covered Person's muscles to relax; (2) cause the Covered Person to lose feeling; or (3) cause the Covered Person to lose consciousness.

(c) Attention Deficit Disorder

The term Attention Deficit Disorder refers to a disease that makes a person have a hard time paying attention, be too impulsive, or be overly active.

(d) Case Management

The term Case Management refers to comprehensive case management programs that serve Covered Persons who have been diagnosed with an injury that is complex, catastrophic, or chronic. The objectives of Case Management are to make it easier for Covered Persons to get the service and care they need in an efficient way, link the Covered Person with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve Covered Persons' health outcomes. Case Management supports Covered Persons and Providers by locating services, coordinating services, and/or evaluating services.

(e) Claims Administrator for Medical and Surgical Services

The claims administrator is the entity responsible for processing claims and making payment to providers. For medical and surgical services, the claims administrator is Independence Blue Cross. The claims administrators for dental, prescription drug, mental health, and vision services are described later in this document.

(f) Compendia

The term Compendia refers to reference documents used by the Fund to determine if a prescription drug should be covered. Compendia provide summaries of how drugs work, information about which drugs are recommended to treat specific diseases, and the appropriate dosing schedule for each drug. Over the years, some Compendia have merged with other publications. The Fund only reviews current Compendia when making coverage decisions.

(g) Covered Expense for Medical/Surgical Services

The term Covered Expense for medical and surgical services refers to the basis on which a Covered Person's Deductibles, Coinsurance, benefit maximums and benefits are calculated. The terms upon which covered expenses for dental, prescription drug, mental health, and vision services are calculated in paid are set forth elsewhere in this document.

(1) For Covered Services provided by a Facility Provider, the term Covered Expenses means the following:

(A) For Covered Services provided by an In-Network Facility Provider or BlueCard PPO Provider, Covered Expense means the amount payable to the Provider under the contractual arrangement in effect with the Claims Administrator.

(B) For Covered Services provided by an Out-of-Network Facility Provider, Covered Expense for Outpatient services means the lesser of the Medicare Allowable Payment for Facilities or the Facility Provider's charges. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the amount specified in the Claim Administrator's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Claims Administrator's applicable proprietary fee schedule, the

amount is determined by reimbursing 50% of the Facility Provider's charges for Covered Services.

- (B) For Covered Expenses provided by an Out-of-Network Facility Provider, Covered Expense for Inpatient services means the Medicare Allowable Payment for Facilities. For Covered Services not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing 50% of the Facility Provider's charges for Covered Services.
- (2) For Covered Services provided by a Professional Provider, the term Covered Expenses means the following:
- (A) For Covered Services provided by an In-Network Professional Provider or BlueCard PPO Provider, Covered Expense means the rate of reimbursement for Covered Services that the Professional Provider has agreed to accept as set forth by contract with the Claims Administrator or the BlueCard PPO Provider.
 - (B) For Covered Services provided by an Out-of-Network Professional Provider, Covered Expense means the lesser of the Medicare Professional Allowable Payment or the Provider's charges for Covered Services. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the amount specified in the Claims Administrator's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Claim Administrator's applicable proprietary fee schedule, the amount is determined by reimbursing 50% of the Professional Provider's charges for Covered Services.
- (3) For Covered Services provided by an Ancillary Service Provider, the term Covered Expenses means the following:
- (A) For Covered Services provided by an In-Network Ancillary Service Provider or BlueCard PPO Provider, Covered Expense means the amount payable to the Provider under the contractual arrangement in effect with the Claims Administrator or BlueCard PPO Provider.
 - (B) For Covered Services provided by an Out-of-Network Ancillary Service Provider, Covered Expense means the lesser of the Medicare Ancillary Allowable Payment or the Provider's charges for Covered Services. For Covered Services that are not recognized or reimbursed by the Medicare traditional program, the amount is determined by reimbursing the lesser of the amount specified in the Claims Administrator's applicable proprietary fee schedule or the Provider's charges. For Covered Services not recognized or reimbursed by the Medicare traditional program or the Claim Administrator's applicable proprietary fee schedule, the amount is determined by reimbursing 50% of the Out-of-Network Ancillary Service Provider's charges for Covered Services.

The Fund does **not pay** for expenses that do not qualify as Covered Expenses.

(h) Covered Service

The term Covered Service refers to a service or supply specified in the Plan for which benefits will be provided by the Fund. The Plan does **not cover** services that do not qualify as Covered Services.

(i) Custodial Care (Domiciliary Care)

The term Custodial Care refers to care provided for Maintenance of the patient or care which is designed essentially to assist the patient in meeting his activities of daily living, and which is not primarily provided

for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes help in tasks that do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively. Such tasks include, but are not limited to walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications.

(j) Essential Health Benefits

For purposes of this Plan, the term Essential Health Benefits refers to: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral treatment; (6) prescription drugs; (7) rehabilitative and habilitative services; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. The scope and definition of the items and services listed above shall be determined in accordance with PPACA and related regulations.

(k) Incurred

A charge is considered Incurred on the date the Covered Person receives the service or supply for which the charge is made.

(l) Inpatient Care For Alcohol Or Drug Abuse And Dependency

The term Inpatient Care For Alcohol Or Drug Abuse And Dependency refers to the provision of medical, nursing, counseling or therapeutic services 24 hours a day in a Hospital or Non-Hospital Facility, according to individual treatment plans.

(m) Inpatient Admission (Inpatient)

The term Inpatient Admission or Inpatient refers to the actual entry of a Covered Person, who is to receive Inpatient services as a registered bed patient, and for whom a room and board charge is made, into any of the following: (1) Hospital; (2) extended care facility; or (3) Facility Provider. The Inpatient Admission will continue until such time as the Covered Person is actually discharged from the facility. ***All Inpatient Admissions, other than an Emergency or maternity admission, must be Precertified in accordance with standards of the Claims Administrator as to the Medical Necessity of the admission.***

(n) Intensive Outpatient Program

The term Intensive Outpatient Program refers to a planned, structured program that coordinates and uses the services of various health professionals, to treat patients in crisis who suffer from Mental Illness, Serious Mental Illness or Alcohol Or Drug Abuse And Dependency. Intensive Outpatient Program treatment is an alternative to Inpatient Hospital treatment or Partial Hospitalization treatment and focuses on alleviation of symptoms and improvement in the level of functioning required to stabilize the patient until the patient is able to transition to less intensive Outpatient treatment, as required.

(o) Medical Care

The term Medical Care refers to services rendered by a Professional Provider for the treatment of an illness or injury. Such services must be rendered within the scope of the Professional Provider's license.

(p) Medically Necessary (Medical Necessity)

The term Medically Necessary services refers to health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. Specifically, the term includes health care services that

a Physician, exercising prudent clinical judgment, would provide to a patient, that are: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; (3) not primarily for the convenience of the patient, Physician, or other health care provider; and (4) not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For purposes of this subsection, the term "generally accepted standards of medical practice" refers to standards that are based on: (1) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community; (2) Physician specialty society recommendations; (3) the views of Physicians practicing in relevant clinical areas; and (4) any other relevant factors. The Plan does **not cover** health care services that are not Medically Necessary.

(q) Medical Policy

The term Medical Policy refers to medical policy used to determine whether Covered Services are Medically Necessary. Medical Policy is developed based on various sources including, but not limited to: (1) peer-reviewed scientific literature published in journals and textbooks; (2) guidelines put forth by governmental agencies; (3) publications of respected professional organizations; and (4) recommendations of experts in the relevant medical specialty.

(r) Medicare Allowable Payment (Facility Providers / Ancillary Service Providers / Professional Providers)

The term Medicare Allowable Payment for Facilities refers to the payment amount, as determined by the Medicare program, for a Covered Service rendered by a Facility Provider. The term Medicare Ancillary Allowable Payment refers to the payment amount, as determined by the Medicare program, for a Covered Service rendered by an Ancillary Service Provider. The term Medicare Professional Allowable Payment refers to the payment amount, as determined by the Medicare program, for a Covered Service based on the Medicare Par Physician Fee Schedule – Pennsylvania Locality 01.

(s) Non-Hospital Residential Treatment

The term Non-Hospital Residential Treatment refers to the provision of medical, nursing, counseling, or therapeutic services to Covered Persons diagnosed with Alcohol Or Drug Abuse And Dependency in a residential environment and according to individualized treatment plans.

(t) Outpatient Care (or Outpatient)

The term Outpatient Care refers to medical, nursing, counseling or therapeutic treatment provided to a Covered Person who does not require an overnight stay in a Hospital or other Inpatient Facility.

(u) Outpatient Diabetic Education Program

The term Outpatient Diabetic Education Program refers to a program provided by an In-Network Provider that has been recognized by the Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

(v) Partial Hospitalization Services

The term Partial Hospitalization Services refers to medical, nursing, counseling or therapeutic services that are: (1) provided on a planned and regularly scheduled basis in a Hospital or Facility Provider; and (2) designed for a patient who would benefit from more intensive services than are offered in Outpatient

treatment (Intensive Outpatient Program or Outpatient office visit) but who does not require Inpatient confinement.

(w) Penalty

A type of cost-sharing in which the Covered Person is assessed a percentage reduction in benefits payable for failure to obtain Precertification of certain Covered Services.

(x) Personal Choice Network

The term Personal Choice Network refers to the network of Providers with whom the Claims Administrator has contractual arrangements.

(y) Plan of Treatment

The term Plan of Treatment refers to a plan of care which is prescribed in writing by a Professional Provider for the treatment of an injury or illness. A Plan of Treatment should include goals and duration of treatment, and be limited in scope to care which is Medically Necessary for the Covered Person's diagnosis and condition.

(z) Precertification (Preapproval)

The term Precertification refers to a prior assessment by the Fund that proposed services, such as hospitalization, are Medically Necessary for a Covered Person and covered by the Plan.

(aa) Preferred Provider Organization (PPO)

The term Preferred Provider Organization (PPO) refers to a type of managed care plan that offers the freedom to choose a Physician like a traditional health care plan and provides the Physician visits and preventive benefits normally associated with an HMO (Health Maintenance Organization). In a PPO, an individual is not required to select a primary care Physician to coordinate care and is not required to obtain referrals to see specialists.

(bb) Prenotification (Prenotify)

The term Prenotification refers to the requirement that the Covered Person provide prior notice to the Fund that proposed services, such as maternity care, are scheduled to be performed. No Penalty will be applied for failure to comply with this requirement. To Prenotify, the Covered Person should call the telephone number listed on the Covered Person's ID card, prior to obtaining the proposed service.

(cc) Totally Disabled (or Total Disability)

The term Totally Disabled Covered Employee refers to a Covered Employee who, due to illness or injury: (1) cannot perform any duty of their occupation or any occupation for which the Covered Employee is, or may be, suited by education, training and experience; and (2) is not, in fact, engaged in any occupation for wage or profit. A Covered Dependent is Totally Disabled if they cannot engage in the normal activities of a person in good health and of like age and sex. A Totally Disabled person must be under the regular care of a Physician.

4.44 TYPES OF PROVIDERS

(a) Providers / In General

(1) *Provider.* The term Provider refers to a Professional Provider, Facility Provider or Ancillary Service Provider, including a pharmacy, which is licensed where required.

An In-Network Provider is a Professional Provider, Facility Provider or Ancillary Service Provider that is a member of one of the Fund's approved Provider Networks and is recognized as such by the appropriate claims administrator to perform specific "in-network" Covered Services at the In-Network level of benefits. An Out-of-Network Provider is a Professional Provider, Facility Provider or Ancillary Service Provider that is **not** a member of one the Fund's approved Provider Networks.

- (2) *Professional Provider.* The term Professional Provider refers to a person or practitioner licensed, where required, and performing services within the scope of such licensure. Professional Providers include the following: (A) Audiologist; (B) Autism Service Provider; (C) Behavior Specialist; (D) Certified Registered Nurse; (E) Chiropractor; (F) Dentist; (G) Independent Clinical Laboratory; (H) Licensed Clinical Social Worker; (I) Master's Prepared Therapist; (J) Nurse Midwife; (K) Optometrist; (L) Physical Therapist; (M) Physician; (N) Podiatrist; (O) Psychologist; (P) Registered Dietitian; (Q) Speech-Language Pathologist; and (R) teacher of the hearing impaired.

An In-Network Professional Provider is a Professional Provider that is a member of one of the Fund's approved Provider Networks and is recognized as such by the appropriate claims administrator to perform specific "in-network" Covered Services at the In-Network level of benefits. An Out-of-Network Provider is a Professional Provider, Facility Provider or Ancillary Service Provider that is **not** a member of one the Fund's approved Provider Networks.

- (3) *Facility Provider.* The term Facility Provider refers to an institution or entity licensed, where required, to provide care. Such facilities include: (A) Ambulatory Surgical Facility; (B) Birth Center; (C) Free Standing Dialysis Facility; (D) Free Standing Ambulatory Care Facility; (E) Home Health Care Agency; (F) Hospice; (G) Hospital; (H) Non-Hospital Facility; (I) Psychiatric Hospital; (J) Rehabilitation Hospital; (K) Residential Treatment Facility; (L) Short Procedure Unit; and (M) Skilled Nursing Facility.

An In-Network Facility Provider is a Facility Provider that is a member of one of the Fund's approved Provider Networks and is recognized as such by the appropriate claims administrator to provide specific "in-network" Covered Services at the In-Network level of benefits. An Out-of-Network Facility Provider is a Facility Provider that is **not** a member of one the Fund's approved Provider Networks.

- (4) *Ancillary Service Provider.* The term Ancillary Service Provider refers to an individual or entity that provides Covered Services, supplies or equipment such as, but not limited to: (A) Infusion Therapy Services; (B) Durable Medical Equipment; and (C) ambulance service.

An In-Network Ancillary Service Provider is an Ancillary Service Provider, including a pharmacy, which is a member of one of the Fund's approved Provider Networks and is recognized as such by the appropriate claims administrator to perform specific "in-network" Covered Services at the In-Network level of benefits. An Out-of-Network Ancillary Service Provider is an Ancillary Service Provider, Facility Provider or Ancillary Service Provider that is **not** a member of one the Fund's approved Provider Networks.

- (5) *BlueCard PPO Provider & BlueCard PPO Program.* The term BlueCard PPO Provider refers to a Provider that participates in the BlueCard PPO Program as an In-Network Provider. The term BlueCard PPO Program refers to a program that allows a Covered Person traveling or living outside of the Plan's area to receive coverage for services at an "in-network" benefit level if the Covered Person receives services from Blue Cross Blue Shield providers that participate in the BlueCard PPO Program.

(b) Providers / Specific Professional Providers for Medical/Surgical Services

- (1) *Certified Registered Nurse.* The term Certified Registered Nurse refers to any one of the following types of nurses who are certified by the state Board of Nursing or a national nursing organization

recognized by the State Board of Nursing: (A) a certified registered nurse anesthetist; (B) a certified registered nurse practitioner; (C) a certified entrostomal therapy nurse; (D) a certified community health nurse; (E) a certified psychiatric mental health nurse; or (F) a certified clinical nurse specialist.

- (2) *Physician*. The term Physician refers to a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), or a Physician's Assistant, licensed and legally entitled to practice medicine and dispense drugs.
- (3) *Psychologist*. The term Psychologist refers to a psychologist who is licensed in the state in which they practice or otherwise duly qualified to practice by a state in which there is no Psychologist licensure.
- (4) *Hospital-Based Provider*. The term Hospital-Based Provider refers to a Physician who provides Medically Necessary services in a Hospital or other In-Network Facility Provider and meets the following requirements:
 - (A) The Medically Necessary services must be supplemental to the primary care being provided in the Hospital or In-Network Facility Provider;
 - (B) The Medically Necessary services must be those for which the Covered Person has limited or no control of the selection of such Physician; and
 - (C) Hospital-Based Providers include Physicians in the specialties of radiology, anesthesiology, pathology, and/or other specialties as determined by the Fund.

When these Physicians provide services other than in the Hospital or other In-Network Facility Provider, they are not considered Hospital-Based providers.

(c) Providers / Specific Facility & Ancillary Service Providers

- (1) *Ambulatory Surgical Facility*. The term Ambulatory Surgical Facility refers to an approved Facility Provider where the Covered Person goes to have Surgery on an Outpatient basis, instead of having to be admitted to a Hospital. It is a Facility Provider which has an organized staff of Physicians, is licensed as required, and has been approved by one of the following: (A) the Joint Commission on Accreditation for Health Care Organizations (JCAHO); (B) the Accreditation Association for Ambulatory Health Care, Inc.; or (C) the Fund. It is also a Facility Provider which has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis, provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility, does not provide Inpatient accommodations, and is not (other than incidentally) a facility used as an office or clinic for the private practice of a Professional Provider.
- (2) *Birth Center*. The term Birth Center refers to a Facility Provider approved by the Fund which is primarily organized and staffed to provide Medical Care, is where a woman can go to receive maternity care and give birth, is licensed as required in the state where it is situated, and is under the supervision of a Physician or a licensed certified nurse midwife.
- (3) *Free Standing Ambulatory Care Facility*. The term Free Standing Ambulatory Care Facility refers to a Facility Provider, other than a Hospital, that provides treatment or services on an Outpatient or partial basis. In addition, the facility: (A) is not, other than incidentally, used as an office or clinic for the private practice of a Physician; and (B) is licensed by the state in which it is located and is accredited by the appropriate regulatory body.
- (4) *Free Standing Dialysis Facility*. The term Free Standing Dialysis Facility refers to a Facility Provider that provides dialysis services for people who have serious kidney disease. In addition, the facility is: (A) primarily engaged in providing dialysis treatment, Maintenance, or training to patients on an

Outpatient or home care basis; (B) licensed or approved by the appropriate governmental agency; and (C) approved by the Fund.

- (5) *Hospital*. The term Hospital refers to an approved facility that provides Inpatient, as well as Outpatient Care, and that meets the requirements of this subsection. The term Hospital specifically refers to a short-term, acute care, general hospital which has been approved by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), and/or by the American Osteopathic Hospital Association or by the Fund, and which meets the following requirements:
- (A) Is a duly licensed institution;
 - (B) Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
 - (C) Has organized departments of medicine;
 - (D) Provides 24-hour nursing service by or under the supervision of Registered Nurses; and
 - (E) Is not, other than incidentally, a Skilled Nursing Facility, nursing home, school, Custodial Care home, health resort, spa or sanitarium, place for rest, place for aged, place for treatment of Mental Illness, place for treatment of Alcohol or Drug Abuse And Dependency, place for provision of rehabilitation care, place for treatment of pulmonary tuberculosis, or place for provision of Hospice care.
- (6) *Independent Clinical Laboratory*. The term Independent Clinical Laboratory refers to a laboratory that performs clinical pathology procedures and that is not affiliated or associated with a Hospital, Physician or Facility Provider.
- (7) *Non-Hospital Facility*. The term Non-Hospital Facility refers to a Facility Provider, licensed by the Department of Health for the care or treatment of Covered Persons diagnosed with Alcohol Or Drug Abuse And Dependency. Non-Hospital Facilities include, but are not limited to, the following for Partial Hospitalization programs: (A) Residential Treatment Facilities; and (B) Free Standing Ambulatory Care Facilities. Non-Hospital Facilities do not include transitional living facilities.

- (8) *Psychiatric Hospital.* The term Psychiatric Hospital refers to a Facility Provider, approved by the Fund, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- (9) *Rehabilitation Hospital.* The term Rehabilitation Hospital refers to a Facility Provider, approved by the Fund, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consists of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Such care is provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- (10) *Residential Treatment Facility.* The term Residential Treatment Facility refers to a Facility Provider licensed and approved by the Fund, which provides treatment for Mental Illness, Serious Mental Illness, or Alcohol Or Drug Abuse And Dependency to partial, Outpatient or live-in patients who do not require acute Medical Care.
- (11) *Short Procedure Unit.* The term Short Procedure Unit refers to a unit which is approved by the Fund and which is designed to handle the following kinds of procedures on an Outpatient basis: (A) lengthy diagnostic procedures; and (B) minor surgical procedures. In the absence of a Short Procedure Unit, these are the procedures which would otherwise have resulted in an Inpatient Admission.

CHAPTER 5—EXCLUSIONS

5.01 IN GENERAL

The Plan does not cover the services and supplies listed in this Chapter. These exclusions are in addition to any other exclusions set forth elsewhere in the Plan.

5.02 GENERAL EXCLUSIONS

(a) Care Rendered by Immediate Family

The Plan does not cover treatment, services or supplies provided by a member of the Covered Person's Immediate Family. The term Immediate Family includes the Covered Person's: (1) spouse; (2) parent; (3) child; (4) stepchild; (5) brother / sister; (6) mother-in-law / father-in-law; (7) brother-in-law / sister-in-law; and (8) son-in-law / daughter-in-law.

(b) Charges in Excess of Benefit Maximums

The Plan does not cover charges Incurred for expenses in excess of benefit maximums specified in the Schedule of Benefits or elsewhere in the Plan.

(c) Charges Incurred After the Date of Termination of the Covered Person's Eligibility

The Plan does not cover charges Incurred after the date of termination of the Covered Person's eligibility under the Plan.

(d) Charges Incurred Prior to Effective Date of Eligibility

The Plan does not cover charges Incurred prior to the Covered Person's effective date of eligibility under the Plan.

(e) Experimental/Investigational Services and Supplies

- (1) *In General.* The Plan does not cover services and supplies which are Experimental/Investigational in nature, except, as approved by the Fund, Routine Patient Costs Associated With Qualifying Clinical Trials that meet the definition of a Qualifying Clinical Trial.
- (2) *Experimental/Investigational.* A drug, biological product, device, medical treatment or procedure is considered Experimental/Investigational if it:
 - Is the subject of ongoing clinical trial(s);
 - Is the research, experimental, study or investigational arm of an ongoing clinical trial(s) or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis;
 - Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;
 - Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the diagnosis or treatment of the Covered Person's particular condition; or
 - Is generally recognized, based on Reliable Evidence, by the medical community as a diagnostic or treatment intervention for which additional study regarding its safety and efficacy for the diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug will not be considered Experimental/Investigational if it has received final approval by the U.S. Food and Drug Administration (FDA) to market with a specific indication for the particular diagnosis or condition present. Any other approval granted as an interim step in the FDA regulatory process, (for example, an Investigational New Drug Exemption as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the established referenced Compendia identified by the Fund recognize the usage as appropriate medical treatment.

A biological product, device, medical treatment or procedure is not considered Experimental/Investigational if it meets all of the criteria listed as follows:

- Reliable Evidence demonstrates that the biological product, device, medical treatment or procedure has a definitive positive effect on health outcomes;
- Reliable Evidence demonstrates that the biological product, device, medical treatment or procedure leads to measurable improvement in health outcomes (that is, the beneficial effects outweigh any harmful effects);
- Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable;
- Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined in the previous bullet, is possible in standard conditions of medical practice, outside clinical investigatory settings; and
- Reliable Evidence shows that prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, and its efficacy as compared with a standard means of treatment for a particular diagnosis.

(3) *Reliable Evidence.* The term Reliable Evidence refers to peer-reviewed reports of clinical studies that have been designed according to accepted scientific standards such that potential biases are minimized to the fullest extent, and generalizations may be made about safety and effectiveness of the technology outside of the research setting. Studies are to be published or accepted for publication in medical or scientific journals that meet nationally recognized requirements for scientific manuscripts and that are generally recognized by the relevant medical community as authoritative. Further, evidence-based guidelines from respected professional organizations and governmental entities may be considered Reliable Evidence if generally accepted by the relevant medical community.

(4) *Qualifying Clinical Trial.* The term Qualifying Clinical Trial refers to a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease Or Condition and is described in any of the following:

- (A) The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
- The National Institutes of Health (NIH);
 - The Centers for Disease Control and Prevention (CDC);
 - The Agency for Healthcare Research and Quality (AHRQ);
 - The Centers for Medicare and Medicaid Services (CMS);
 - Cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);

- Any of the following, if the Conditions for Departments are met: (A) the VA; (B) the DOD; or (C) the Department of Energy (DOE). The term Conditions for Departments refers to the need for review and approval through a system of peer review that the Government determines to be comparable to the system of peer review studies and investigations used by NIH and assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review.
- (B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA).
- (C) The study or investigation is regarding a drug that is exempt from having such an investigational new drug application.

In the absence of meeting the criteria listed above, the Clinical Trial must be approved by the Fund as a Qualifying Clinical Trial.

- (5) *Routine Patient Costs Associated With Qualifying Clinical Trials.* Routine patient costs include all items and services consistent with the coverage provided under the Plan that is typically provided for a Qualified Individual who is not enrolled in a clinical trial. Routine patient costs do not include: (A) the investigational item, device or service itself; (B) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and (C) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

To ensure coverage and appropriate claims processing, the Claims Processor must be Prenotified of the Covered Person's participation in a Qualifying Clinical Trial. Benefits are payable if the Qualifying Clinical Trial is conducted by an In-Network Professional Provider, and conducted in an In-Network Facility Provider. If there is no comparable Qualifying Clinical Trial being performed by an In-Network Professional Provider, and in an In-Network Facility Provider, then the Fund will consider the services by an Out-of-Network Provider, participating in the clinical trial, as covered if the clinical trial is deemed a Qualifying Clinical Trial by the Fund.

- (6) *Qualified Individual.* The term Qualified Individual refers to a Covered Person who meets the following conditions: (A) the Covered Person is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other Life-Threatening Disease or Condition; and either (B) the referring health care professional is a health care provider participating in the clinical trial and has concluded that the Covered Person's participation in such trial would be appropriate based upon the individual meeting the conditions described above; or (C) the Covered Person provides medical and scientific information establishing that their participation in such trial would be appropriate based upon the Covered Person meeting the conditions described above.
- (7) *Life-Threatening Disease or Condition.* The term Life-Threatening Disease or Condition refers to any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(f) Immunizations for Employment or Travel

The Plan does not cover immunizations required for employment purposes or travel. This exclusion does not apply to immunizations required for travel which are required by the Advisory Committee on Immunization Practices (ACIP).

(g) Medical Necessity / The Plan Does Not Cover Services And Supplies That Are Not Medically Necessary

The Plan does not cover services and supplies that are not Medically Necessary as determined by the Fund for the diagnosis or treatment of illness or injury.

(h) Military Service

The Plan does not cover any loss sustained or expenses Incurred in the following ways: (1) during military service while on active duty as a member of the armed forces of any nation; or (2) as a result of enemy action or act of war, whether declared or undeclared.

(i) Motor Vehicle

The Plan does not cover injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law.

(j) Non-Covered Services / Non-Covered Expenses

The Plan does not cover any services, supplies or treatments not specifically listed as Covered Services under the Plan. Covered Services must be billed to be covered. The Plan also does not cover expenses which do not qualify as Covered Expenses or are in excess of the amount considered to be a Covered Expense.

(k) Over-The-Counter and Other Drugs

- (1) The Plan does not cover over-the-counter drugs and any other medications that may be dispensed without a doctor's prescription, except for medications administered during an Inpatient Admission. This exclusion does not apply to over-the-counter medicines that are prescribed by a Physician in accordance with applicable law.
- (2) Chapter 4 of the Plan does not cover drugs or medicines that are covered under Chapter 6 of the Plan.
- (3) Chapter 4 of the Plan does not cover drugs or medicines that can be administered safely and effectively by either the Covered Person or a caregiver, without medical supervision, regardless of whether initial medical supervision and/or instruction is required, and regardless of whether drugs or medicines are provided or administered by a Provider. This exclusion does not apply to drugs or medicines that are mandated to be covered by law unless covered by Chapter 6 of the Plan, or drugs or medicines required for treatment of an Emergency condition.

(l) Personal Hygiene and Convenience Items

The Plan does not cover personal hygiene and convenience items such as, but not limited to the following, whether or not recommended by a Provider: (1) air conditioners; (2) humidifiers; (3) physical fitness or exercise equipment; (4) radio; (5) beauty/barber shop services; (6) guest trays; (7) wigs; (8) chairlifts; (9) stairglides; (10) elevators; (11) sauna; (12) television; (13) spa or health club memberships; (14) whirlpool; (15) telephone; (16) guest service; or (17) hot tub or equivalent device.

(m) Responsibility of Another Party

The Plan does not cover services and supplies for which a Covered Person would have no legal obligation to pay, for which another party has primary responsibility, or for which a third party may be liable. The Plan also does not cover services and supplies received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.

(n) Responsibility of Medicare

The Plan does not cover charges for services and supplies that are paid or payable by Medicare when Medicare is primary. A charge for a service or supply is payable under Medicare when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premiums for, maintains, claims or receives Medicare benefits.

(o) Travel

The Plan does not cover travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out-of-area Provider.

(p) Veteran's Administration or Department of Defense

The Plan does not cover services and supplies to the extent a Covered Person is legally entitled to receive such services when provided by the Veteran's Administration or by the Department of Defense in a government facility reasonably accessible by the Covered Person.

(q) Worker's Compensation

The Plan does not cover services and supplies for any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of worker's compensation law or any similar occupational disease law or act. This exclusion applies whether or not the Covered Person claims the benefit or compensation.

5.03 SPECIFIC EXCLUSIONS

(a) Alternative Therapies / Complementary Medicine

The Plan does not cover alternative therapies / complementary medicine, including but not limited to: (1) music therapy; (2) dance therapy; (3) equestrian/hippotherapy; (4) homeopathy; (5) primal therapy; (6) rolfing; (7) psychodrama; (8) vitamin or other dietary supplements and therapy; (9) naturopathy; (10) hypnotherapy; (11) bioenergetics therapy; (12) qi gong; (13) ayurvedic therapy; (14) aromatherapy; (15) massage therapy; (16) therapeutic touch; (17) recreational, wilderness, educational and sleep therapies; (18) traditional Chinese medicine; (19) mind-body interventions; (20) meditation; (21) reiki; (22) energy therapies; and (23) bioelectromagnetic therapies. Alternative therapies / complementary medicines are identified in part by reference to the definition from the National Institute of Health's National Center for Complementary and Alternative Medicine.

(b) Care that Extends Beyond Traditional Medical Management

The Plan does not cover any care that extends beyond traditional medical management (except as otherwise provided herein) for: (1) autistic disease of childhood; (2) Pervasive Developmental Disorders; (3) Attention Deficit Disorder; (4) learning disabilities; (5) behavioral problems; (6) intellectual disability; (7) treatment or care to effect environmental or social change; or (8) Autism Spectrum Disorders.

(c) Diagnostic Screening Examinations / Physical Examinations for Non-Preventive Purposes

The Plan does not cover diagnostic screening examinations, except for mammograms and preventive care as provided in the Preventive Care and other relevant provisions of the Plan.

The Plan also does not cover routine physical examinations for non-preventive purposes, such as pre-marital examinations, physicals for college, camp or travel, and examinations for insurance, licensing and employment.

(d) Hearing Aids

- (1) *In General.* The Plan does not cover Hearing Aids, including cochlear electromagnetic hearing devices, and hearing examinations or tests for the prescription for fitting of Hearing Aids. Services and supplies related to these items are not covered.
- (2) *Definition of Hearing Aid.* A Prosthetic Device that amplifies sound through simple acoustic amplification or through transduction of sound waves into mechanical energy that is perceived as sound. A Hearing Aid is comprised of the microphone to pick up sound, an amplifier to increase the sound, a receiver to transmit the sound to the ear, and a battery for power. A Hearing Aid may also have a transducer that changes sound energy into a different form of energy. The separate parts of a Hearing Aid can be packaged together into a small self-contained unit, or may remain separate or even require surgical implantation into the ear or part of the ear. Generally, a Hearing Aid will be categorized into one of the following common styles: (A) behind-the-ear; (B) in-the-ear; (C) in-the-canal; (D) completely-in-the-canal; or (E) implantable (can be partial or complete). A Hearing Aid is not a cochlear implant.

(e) High Cost Technical Equipment

Unless the acquisition from a Professional Provider was approved through the certificate of need (CON) process and/or by the Fund, the Plan does not cover equipment costs related to services performed on high cost technological equipment as defined and determined by the Fund, such as, but not limited to computer tomography (CT) scanners, magnetic resonance imagers (MRI), and linear accelerators.

(f) Home Blood Pressure Machines

The Plan does not cover home blood pressure machines, except for Covered Persons with pregnancy-induced hypertension, with hypertension complicated by pregnancy, and with end-stage renal disease receiving home dialysis.

(g) Relative Counseling or Consultations

The Plan does not cover counseling or consultation with a Covered Person's relatives, or Hospital charges for a Covered Person's relatives or guests, except as may be specifically provided or allowed in the Treatment for Alcohol Or Drug Abuse And Dependency or Transplant Services sections of the Plan.

(h) Temporomandibular Joint Syndrome (TMJ)

Chapter 4 of the Plan does not cover treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension.

(i) Select Medical Supplies

The Plan does not cover certain medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits.

(j) Vision

Chapter 4 of the Plan does not cover correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy and all related services. Please refer to the Vision Benefit provisions of the Plan for information regarding coverage of eyeglasses, lenses, contact lenses, the fitting of such lenses, and vision examinations.

(k) Miscellaneous

- (1) The Plan does not cover care in a nursing home, home for the aged, convalescent home, school, camp, institution for intellectually disabled children, or Custodial Care in a Skilled Nursing Facility.
- (2) The Plan does not cover broken appointments, telephone consultations, completion of a claim form, marriage counseling, Custodial Care, domiciliary care, or rest cures.
- (3) The Plan does not cover charges for services or supplies which are not billed and performed by a provider as defined under the Plan as a Professional Provider, Facility Provider, Ancillary Service Provider except as otherwise indicated under the sections of the Plan entitled Therapy Services and Ambulance Services.
- (4) The Plan does not cover services performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a Hospital or university.
- (5) The Plan does not cover services and supplies related to weight reduction or premarital blood tests. This exclusion does not apply to the section of the Plan entitled Nutrition Counseling for Weight Management or Surgery for the treatment of obesity as set forth in the section of the Plan entitled Surgical Services.

CHAPTER 6—PRESCRIPTION DRUG BENEFITS

6.01 PRESCRIPTION DRUG PROGRAM

(a) Schedule of Benefits

Type of Drug	Your Cost If You Use A Retail Pharmacy / Up To 34-Day Supply	Your Cost If You Use A Retail Pharmacy / 31 to 90-Day Supply	Your Cost If You Use Home Delivery / 31 to 90-Day Supply
Generic Drugs	\$7 Copayment	\$21 Copayment	\$15 Copayment
Preferred Brand Drugs	\$15 Copayment	\$45 Copayment	\$40 Copayment
Non-Preferred Brand	\$30 Copayment	\$90 Copayment	\$60 Copayment

(b) Limitations

- (1) *Out-of-Network Drugs Not Covered.* Drugs purchased out-of-network are not covered under the Plan's Prescription Drug Program.
- (2) *Brand-Name Drug When Generic Equivalent Is Available.* If a Covered Person purchases a brand-name drug when a generic equivalent is available, the Covered Person must pay the applicable Copayment plus the difference in cost between the brand-name drug and the generic drug.
- (3) *Specialty Medications Covered Under Medical Benefit Provisions of the Plan.* Specialty Medications are covered under the Medical Benefit provisions as set forth in Chapter 4 when they are administered in an office or facility setting. Specialty Medications obtained through a pharmacy are subject to the provisions of the Schedule of Benefits set forth in paragraph 6.01(a) above.

6.02 PHARMACEUTICAL BENEFIT MANAGER

(a) Express Scripts

To help save you and the Fund money, the Trustees have designated Express Scripts as the Fund's Pharmaceutical Benefit Manager (PBM) to oversee the Plan's Prescription Drug Program and provide a prescription drug card to Covered Persons. This is a consumer-driven benefit that allows you to obtain prescriptions under the Co-Payment schedule set forth above for generic and brand-name drugs, subject to the Plan's Prescription Drug Program limitations. You will need to present your prescription drug card to your pharmacy for any prescriptions that you and your Eligible Dependents purchase. If you need help, please call the member services phone number shown on the back of your prescription drug card.

(b) Covered Prescription Drugs | The Formulary

The Plan covers drugs listed in Express Scripts' Formulary. The term Formulary refers to the version of Express Scripts' official list of covered drugs used by the Fund. To help control prescription drug costs and to help maintain the Plan's Prescription Drug Program, the Trustees may agree to accept changes to the Formulary that may result in the removal of medications from the Formulary or require you to obtain Precertification for Medical Necessity. This may result in the Plan not covering certain drugs or denying claims for medications in cases where you do not obtain Precertification for Medical Necessity.

(c) Special Programs

- (1) *Review Programs.* To help control prescription drug costs for you and the Fund, the Trustees may authorize the Fund to participate in certain clinical and utilization review programs, including programs similar to the foregoing. Among other things, these programs may require you to obtain

certain medications from designated pharmacies or the home delivery service. In addition, these programs may impose prior approval requirements or quantity limits on certain medications. These programs may also come in the form of step therapy, a program that reduces waste by promoting the use of generics for people who take prescription drugs regularly to treat a medical condition, such as arthritis, asthma or high blood pressure.

- (2) *Fraud, Waste and Abuse.* The Trustees may authorize Express Scripts to monitor physician and patient prescription drug utilization patterns to help the Fund reduce health risks and unnecessary spending associated with fraud, waste and abuse. Such monitoring enables to the Fund to identify potential problem prescribers and unusual or excessive utilization patterns. When Express Scripts identifies an unusual or excessive pattern of prescription drug use, the Trustees may authorize Express Scripts to restrict the filling of that prescription drug to one designated pharmacy or restrict a patient to a single physician for the prescribing of prescription drugs.
- (3) *Drug Quantity Management.* Many prescription drugs are available at various strengths and their total cost may vary depending on the dosage strength. At times, for example, it may be more cost-effective to receive a daily dose of a 100mg tablet versus a daily dose of two 50mg tablets. Evaluating the cost-effectiveness of a particular drug dosage is referred to as drug quantity management. The Trustees may authorize Express Scripts to engage in drug quantity management in an effort control prescription drug costs for you and the Fund.

CHAPTER 7—DENTAL, VISION & VACATION BENEFITS

7.01 DENTAL BENEFITS

The Fund has retained Delta Dental to make available an expansive group of dental care providers to you and your family. You may find a provider that participates with Delta Dental by visiting their website: www.deltadentalins.com. You may also call Delta Dental’s customer service number at (800) 932-0783.

The following schedule of dental benefits includes a listing of applicable deductibles and maximums along with a wide variety of covered services along with their cost to you. (Please note that the amount payable by you will be based on Delta Dental’s maximum contract allowances and not necessarily each dentist’s submitted fees.)

DEDUCTIBLES & MAXIMUMS			
Annual Deductibles	\$50 per Covered Person / \$150 per Covered Family		
Annual Maximums	\$1,000 per Covered Person		
BENEFITS AND COVERED SERVICES	YOUR COST IF YOU USE AN IN-NETWORK PROVIDER	YOUR COST IF YOU USE AN OUT-OF-NETWORK PROVIDER	
Diagnostic and Preventive Services (D&P) Exams, Cleanings, X-Rays and Sealants	None No Deductible	None No Deductible	
Basic Services Fillings and Simple Tooth Extractions	None	None	
Endodontics (Root Canals) Covered Under Basic Services	None	None	
Non-Surgical Periodontics	None	None	
Oral Surgery Covered Under Basic Services	None	None	
Major Services Crowns, Inlays, Onlays, and Cast Restorations	45%	45%	
Prosthodontics Bridges and Dentures	45%	45%	
Orthodontic Benefits Dependent Children	45% \$2,500 Lifetime Maximum No Deductible		

7.02 VISION BENEFITS

The Independence Blue Cross Vision Program, administered by Davis Vision, offers Covered Persons comprehensive benefits, including routine eye care, frames and lenses. Benefits are maximized by using Davis Vision providers that are conveniently located throughout the area. In addition, paid-in-full benefits for eyeglasses with standard lenses are available when you choose from a select grouping known as the Davis Collection of Frames. The following schedule of vision benefits includes a listing of covered services along with their cost to you.

BENEFITS	COVERAGE
Eye exam, including refraction and glaucoma screening, and dilation, as professionally indicated Participating providers Non-participating providers	\$0 Copay Up to \$35 reimbursement to Covered Person ¹
Eyeglasses, including spectacle lenses and frames, at participating providers Spectacle lenses Additional lens options Frames	Spectacle lenses covered at no extra cost include: all range of prescriptions, oversize lenses, glass or plastic lenses, single vision, bifocal, trifocal or lenticular lenses. Additional spectacle lens options covered at no cost include: glass grey #3 prescription sunglass lenses, tinting and polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/- 6.00 diopters Choose from participating provider's own frame collection and Covered Person receives allowance of \$60 ² OR Choose from the Davis Collection of Frames that is available at most participating providers and Covered Person pays: Fashion Selection: \$0 Designer Selection: \$0 Premier selection: \$20
Eyeglasses, including spectacle lenses and frames, at non-participating providers	Eyeglasses (spectacle lenses and frames) are available up to a \$75 reimbursement to Covered Person ¹
Contact lenses (in lieu of eyeglasses) including standard, specialty and disposable lenses and evaluation and fitting Participating providers Non-participating providers	Covered Person receives allowance up to \$75 ² Up to \$75 reimbursement to Covered Person ¹
Benefit frequency	Once every two calendar years
Network	Davis Vision Network To locate a participating provider, go to www.ibx.com and click on the 'Find a Doctor' feature.

1 In lieu of participating provider benefit, Covered Person is responsible for balance.

2 Covered Person is responsible for balance.

7.03 VACATION BENEFITS

Certain chapters within Bricklayers and Allied Craftworkers Local 1 of PA/DE have voted to make available a vacation benefit as part of their overall benefits package. This benefit is administered through a separate, segregated component of the Health & Welfare Fund that is known as the Vacation Fund.

The Vacation Fund establishes a separate account for each participating Eligible Employee into which after-tax Employer contributions are deposited for each hour of Covered Employment. The balance of each account, subject to an administrative fee as set by the Trustees, is automatically distributed twice per year. Contributions remitted for the months of November through April will be distributed during the second week of June. Contributions remitted for the months of May through October will be distributed during the second week of December. If you die, the balance of your account will be distributed to your Designated Beneficiary as determined in accordance with Section 8.03.

Vacation benefit payments which are not cashed or which are returned will be held in your individual account. If you do not contact the Fund Office to claim your benefits for a period of five years from the date of the last deposit of Employer contributions, your account will be closed and the unclaimed amounts will be used to pay the operating expenses of the Fund.

CHAPTER 8—DEATH / ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

8.01 IN GENERAL

In order to ensure that you and/or your loved ones are financially secure in the unfortunate event of your death, accidental death, or if you incur a dismemberment, the Trustees have secured a fully-insured life and accidental death & dismemberment (AD&D) policy with Amalgamated Life Insurance Company.

Subject to the terms, conditions, and limitations of the policy, the Designated Beneficiary of an Eligible Employee, or Eligible Retiree who retired prior to September 1, 2007 will be eligible for payment in the event of the death of the Eligible Employee or Eligible Retiree. AD&D Benefits are payable to an Eligible Employee for losses other than the loss of life.

8.02 SCHEDULE OF DEATH / ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

(a) Schedule of Benefits

- (1) *Death Benefit.* The Plan's death benefit is \$10,000.
- (2) *AD&D Benefit.* The Plan's AD&D benefit is \$10,000.
- (3) *Special Retiree Benefit.* If you are an Eligible Retiree who retired prior to September 1, 2007, you are eligible for a death benefit of \$10,000.

(b) AD&D Benefit Limitations

- (1) *Amount Payable.* The amount payable as shown in the Schedule of Benefits for AD&D is paid for the loss of life, both hands or both feet, or sight of both eyes. Such amount is also payable in the event of the loss of any two or more of the following: one foot, one hand, and sight of one eye. One-half of the amount payable as shown in the Schedule of Benefits for AD&D is paid for the loss of one hand, one foot, or sight of one eye.
- (2) *Definitions.* Loss of one hand or foot means loss by cutting off at, or above the wrist or ankle joint. Loss of sight means total loss that cannot be recovered. If an Eligible Employee incurs more than one loss due to one accident, payment will be made only for the loss with the largest benefit. Additionally, payment will be made only for the loss that results from the accident without regard to any former loss.
- (3) *Time Limit to File Claim & Proof of Claim.* Written notice of the event on which a claim is based must be provided to the life insurance carrier no later than thirty (30) days after the loss for which the claim is made. Late notice will be accepted only if it is shown to have been furnished as soon as reasonably possible. Written proof in support of the claim must be provided to the life insurance carrier no later than ninety (90) days after the date of loss for which the claim is made. Late proof will be accepted only if it is shown to have been furnished as soon as reasonably possible.
- (4) *Exclusions.* AD&D Benefits are only payable for losses: (A) caused by accident; (B) that are the result of the injury, directly and independently of all other causes; and (C) occur within ninety (90) days after the injury. No AD&D benefits are payable for losses resulting from or caused directly or indirectly by: (A) war or any act of war; (B) bodily or mental infirmity; (C) disease or illness of any kind; (D) medical or surgical treatment (except medical or surgical treatment made necessary solely by injury); (E) bacterial infection; (F) intentionally self-inflicted injury; (G) suicide or any attempt thereat; (H) alcohol and substance abuse; (I) injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft except while a fare-paying passenger

in any aircraft then licensed to carry passengers; and (J) commission of or participation in a crime.

(5) *Termination of AD&D Coverage.* AD&D coverage terminates at the earlier of retirement or age 70.

8.03 DESIGNATED BENEFICIARY

(a) In General

Designated Beneficiary means the person(s) properly named to receive benefits under the Plan. If the Death Benefit is payable to a minor, it may be paid to the legally appointed guardian of the minor or, if there is no guardian, to the adult(s) assuming physical custody and principal support of the minor.

(b) Procedure for Naming a Designated Beneficiary

A Designated Beneficiary must be named in a writing provided to the Fund Office, and may be changed from time to time. No designation or change shall be binding unless the Fund Office receives the written instrument making such designation or change. Upon receipt, it shall be effective as of the date of execution but without prejudice to the Fund on account of a payment made or an action taken or permitted by the Fund before receipt of the designation or change. Consent of the Designated Beneficiary is not required to change the designation.

(c) Failure to Name a Designated Beneficiary.

If, at the time of death, a proper designation is not on file at the Fund Office or if the Designated Beneficiary does not survive the Eligible Employee or Eligible Retiree, the Death Benefit will be payable as follows:

- (1) To the surviving spouse, if any, of the Eligible Employee or Eligible Retiree; but if none, then;
- (2) In equal shares to the surviving child(ren), if any, of the Eligible Employee or Eligible Retiree; but if none, then;
- (3) In equal shares to the surviving parent(s), if any, of the Eligible Employee or Eligible Retiree; but if none, then;
- (4) In equal shares to the surviving sibling(s), if any, of the Eligible Employee or Eligible Retiree; but if none, then;
- (5) All to the executor or administrator of the estate of the Eligible Employee or Eligible Retiree.

8.04 CONFLICT

In the event of a conflict between this Chapter and the policy, the policy will govern.

CHAPTER 9—COORDINATION OF BENEFITS

9.01 COORDINATION OF BENEFITS IN GENERAL.

Members of a family are often covered under more than one group health plan, which could result in duplication of health coverage. To avoid this, the health care benefits provided by this Plan are coordinated with similar benefits payable under other plans.

Benefits payable for Covered Expenses Incurred by a Covered Person who also is covered under or entitled to benefits from another group health plan must be coordinated so that the total amount payable does not exceed 100% of the expenses actually incurred.

9.02 HOW BENEFITS ARE COORDINATED

(a) Coordination with Other Group Health Plans

If a Covered Person has duplicate health care coverage, benefits are coordinated by looking first to what is called the “primary plan.” If any charges remain to be paid, then the “secondary plan” pays in accordance with its own provisions.

If another group health plan covering the Covered Person does not contain a Coordination of Benefits provision, it is the primary plan. If another group health plan covering the Covered Person contains a Coordination of Benefits provision, the following rules are used to determine whether a plan is considered primary or secondary:

- (1) The plan covering the patient other than as a dependent is primary.
- (2) If a child who is covered as a dependent under different plans and the parents are not separated or divorced, the plan of the parent whose birthday (excluding year of birth) falls earlier in the calendar year is primary, and the plan of the parent whose birthday (excluding year of birth) falls later in the calendar year is secondary. If both parents have the same birthday, the plan which covered the parent longer is primary. However, if the other plan does not have a birthday rule and instead has a rule based upon gender of the parent, and, as a result of this, the plans do not agree which is primary, the rule in the other plan will control unless the parents are separated or divorced.
- (3) If a child’s parents are separated or divorced and there is no joint custody agreement, benefits for the child are paid: (A) first, by the plan covering the child as a dependent of the parent with custody; (B) second, by the plan of the new spouse of the parent with custody of the child; and (C) finally, by the plan of the parent not having custody of the child.
- (4) If there is a court decree in a divorce or custody case which establishes financial responsibility for the health care expenses of a child and the plan that covers the parent with such financial responsibility has actual knowledge of the court decree, that plan is primary. This rule will be applied before (1) or (2) above.
- (5) If there is a court decree in a divorce or custody case, but such decree states that the parents are to share joint custody without stating that one of the parents is responsible for the health care expense of the child, the Plan covering the child will follow the rules outlined in (2) above. Under these circumstances, and for purposes of (2) above, the parents will not be treated as separated or divorced.
- (6) The plan covering the patient as an employee who is neither laid off nor retired (or as that employee’s dependent) is primary to a plan which covers that patient as a laid off or retired

employee (or as that employee's dependent). However, 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 does not apply.

- (7) If none of the rules set forth above apply, the plan which covered the employee longer will be primary.

(b) Effect on Benefits

When this Plan is secondary, the benefits payable under the Plan will be reduced so that the Fund will pay no more than the difference, if any, between the benefits provided under the primary plan for Covered Services and the total Covered Expenses Incurred by the Covered Person. Benefits payable under another plan include benefits that would have been payable had the claim been duly made before. In no event will the Fund's payment exceed the amount that would have been payable under the Plan if it were primary.

If benefits are reduced under the primary plan because a Covered Person does not comply with a relevant plan provision, or fails to maximize benefits under the plan, the amount of such reduction will not be covered under this Plan.

9.03 RIGHT TO INFORMATION.

For purposes of determining the applicability and implementation of this Chapter or a provision of similar purpose of another group health plan, the Board of Trustees, without the consent of or notice to any person, may release to, or may obtain from, any insurance company, organization, or person any information that the Board of Trustees deems necessary for such purposes (to the extent permitted under the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to HIPAA). An individual claiming benefits under the Plan shall furnish, upon request by the Fund, information, in writing, as may be requested to implement this provision.

The Fund, however, is not required to determine the existence of any other plan or the amount of benefits payable under any such plan, and the payment of benefits under this Plan will be affected by the benefits that would be payable under any and all other plans only to the extent the Fund is furnished with information relative to such other plans.

9.04 RIGHT TO CORRECT ERRONEOUS PAYMENTS.

Whenever a payment that should have been made under the Plan in accordance with this Chapter has been made under another group health plan, the Board of Trustees shall have the right, exercisable alone and at its sole discretion, to pay to the organization making such payment an amount it shall determine to be warranted in order to satisfy the intent of this Chapter; the amount so paid shall be deemed to be a benefit provided under the Plan, and, to the extent of such payment, the Fund shall be fully discharged from liability. The Plan also reserves the right to seek recovery for any excess paid by it over the maximum it should have paid under this Chapter, from any insurance company, other plan(s), or any person to or from whom payments were made.

CHAPTER 10—REIMBURSEMENT & SUBROGATION

10.01 RIGHT TO RECOVER PAYMENTS

(a) Fraudulent Claims

If a fraudulent claim is submitted, benefits will be denied. A Covered Person must reimburse the Fund for any fraudulent claim paid in error.

(b) Erroneous Payments

A Covered Person must reimburse the Fund for any claim that is paid in error because of a mistake of law or fact. Additionally, a Covered Person must reimburse the Fund for any payment in excess of the amount necessary at that time to satisfy the intent and provisions of the Plan, irrespective of to whom paid.

(c) Payments Made Due to Failure to Update Enrollment Status

A Covered Person must reimburse the Fund for any claim paid in error by the Fund because the Covered Person failed to update the Covered Person's enrollment status or the status of the Covered Person's previously enrolled dependents. Important events that must be reported to the Fund Office include divorce, legal separation, loss of custody, loss of Eligible Dependent status, and any other event that impacts the eligibility of the Covered Person or the Covered Person's dependent(s).

(d) Recovery of Improper Payments Described in this Section

If the Fund pays a claim in error, or makes any payment in excess of the amount necessary at that time to satisfy the intent and provisions of the Plan, the improperly paid amount may be deducted from any benefits due to the Covered Person and his or her Eligible Dependents until the Fund is reimbursed for the amount improperly paid. The Fund may take any other action it deems appropriate to recover any improperly paid amount against one or more of the following parties: (1) the recipient of the payment; (2) the Covered Person with respect to whom the payment was made; (3) an insurance company; and (4) any other person, organization or entity. The Covered Person will be liable to the Fund for all of its expenses, including attorneys' fees, related to the cost of collecting any improperly paid amount.

10.02 REIMBURSEMENT OF CONDITIONAL BENEFIT PAYMENTS

(a) In General

(1) *Conditional Benefit Payments.* The Plan does not provide benefits to diagnose and treat illnesses or injuries for which a third party may be responsible or liable. However, if a Covered Person incurs an illness or injury for which a third party may be responsible or liable, the Fund may make one or more conditional benefit payments to or on behalf of the Covered Person to cover claims arising from such illness or injury. Such payments are conditioned upon the Covered Person's compliance with this Chapter, including all of the Covered Person's obligations set forth in this Section.

(2) *Agreement to Reimburse the Fund.* By accepting conditional benefit payments from the Fund, the Covered Person agrees to reimburse the Fund for claims paid up to the full amount of any recovery arising from the illness or injury. The Covered Person agrees that any amounts recovered by judgment, settlement, or otherwise will be applied first to reimburse the Fund, without reduction for attorneys' fees and other costs, even if the Covered Person is not made whole, regardless of whether the amounts recovered are designated to cover medical expenses, and regardless of how the amounts recovered are characterized. Finally, the Covered Person agrees that the Fund's right to reimbursement as described in this Section applies irrespective of the Covered Person's cause of

action, demand, claim, right of recovery, judgment, order, award, settlement, or compromise against or with the third party, regardless of whether the Covered Person actually obtains the full amount of such judgment, order, award, settlement or compromise, and regardless of whether the third party is found responsible or liable (or admits responsibility or liability) for the illness or injury.

- (3) *Equitable Lien.* By accepting conditional benefit payments from the Fund, the Covered Person agrees that the Fund will have a first priority equitable lien on the amount of any recovery arising from the illness or injury. The Covered Person further agrees that, except as otherwise provided in paragraph 5 of this subsection: (A) the amount of any recovery arising from the illness or injury is due and owing to the Fund and is an asset of the Fund; (B) the equitable lien on the amount of any recovery arising from the illness or injury is an asset of the Fund; and (C) the Covered Person, or anyone acting on the Covered Person's behalf, will be considered a fiduciary under Section 3(21) of ERISA with respect to such Fund assets to the extent he or she exercises control over such Fund assets. Control over such Fund assets includes, but is not limited to, the disposition of such Fund assets.

Among other things, the Fund's fiduciaries must act prudently, for the exclusive benefit of the Fund's participants and beneficiaries, and in accordance with the Fund's governing documents (e.g., this Chapter). As previously stated, this Chapter requires Covered Persons who accept conditional benefit payments from the Fund to reimburse the Fund for claims paid up to the full amount of any recovery arising from the illness or injury.

- (4) *Right to Reimbursement Not Impacted By Equitable/Legal Doctrines.* The Fund's right to reimbursement as described in this Section will not be reduced, eliminated or otherwise affected by the make whole doctrine, comparative fault or regulatory diligence, the common fund doctrine, or any other equitable or legal doctrine.
- (5) *Amounts Recovered in Excess of Claims Paid.* Amounts recovered by the Covered Person in excess of conditional benefit payments made by the Fund are the separate property of the Covered Person.

(b) Acknowledgement Form Required

If a Covered Person incurs an illness or injury for which a third party may be responsible or liable, then, in order to receive one or more conditional benefit payments from the Fund to cover claims arising from such illness or injury, the Covered Person and the Covered Person's attorney (if any) must sign a Subrogation and Reimbursement Agreement/Acknowledgement of Plan Provisions Form (Acknowledgement Form) before any conditional benefit payments are made. If the Covered Person or the Covered Person's attorney (if any) refuse to sign the Acknowledgement Form, the Fund may withhold conditional benefit payments and may recoup by offset, lawsuit, or other appropriate means any amount already paid. The Fund's right to reimbursement as described in this Section is governed by the terms of the Plan whether or not the Covered Person or the Covered Person's attorney (if any) has signed the Acknowledgement Form.

(c) Notification / No Settlements or Disbursements Without the Fund's Consent / Cooperation

- (1) *Obligation to Notify the Fund Office.* A Covered Person is obligated to notify the Fund of any illness or injury for which a third party may be responsible or liable. By accepting conditional benefit payments from the Fund, the Covered Person agrees to notify the Fund Office promptly of efforts made to recover from a third party, including (but not limited to) filing a lawsuit to recover amounts in connection with the illness or injury. Furthermore, in the event the Covered Person, or someone acting on the Covered Person's behalf, receives payment from any source for claims related to the illness or injury, the Covered Person must notify the Fund Office immediately.

- (2) *No Settlements or Disbursements.* By accepting conditional benefit payments from the Fund, the Covered Person agrees that neither the Covered Person nor anyone acting on the Covered Person's behalf will settle any claim related to the illness or injury without the written consent of the Fund. The Covered Person further agrees that the amount of any recovery arising from the illness or injury will remain in the possession of the Covered Person, or someone acting on behalf of the Covered Person, and be placed and held in a specifically identifiable segregated account. Finally, the Covered Person agrees that neither the Covered Person nor anyone acting on the Covered Person's behalf will distribute the amount of any recovery arising from the illness or injury without a release from the Fund of the Fund's right to reimbursement as described in this Section.
- (3) *Cooperation.* By accepting conditional benefit payments from the Fund, the Covered Person agrees to cooperate fully with the Fund in connection with any claim brought by the Fund to assert its right to reimbursement. The Covered Person further agrees to refrain from doing anything to impair, prejudice, or discharge the Fund's right to reimbursement. The Covered Person further agrees to execute and deliver any and all documents required by the Fund and do whatever else is necessary to fully protect the Fund's right to reimbursement. Finally, the Covered Person must provide the Fund with any information the Fund requires so that the Fund may successfully assert its right to reimbursement.

(d) Remedies

If a Covered Person fails to comply with this Section (e.g., fails to reimburse the Fund in accordance with this Section or otherwise fails to meet the Covered Person's obligations under this Section), the Fund may take one or more of the following actions:

- (1) *Legal Action.* The Fund may bring suit to collect the full amount of the conditional benefit payments made to or on behalf of the Covered Person. The Fund may bring such a suit against the Covered Person, anyone acting on the Covered Person's behalf, insurers, any recipient(s) of Fund assets improperly distributed without the consent of the Fund, and any other person, organization, or entity. If it becomes necessary for the Fund to bring suit against the Covered Person for failure to comply with this Section: (A) the Covered Person will be liable to the Fund for all of its expenses, including attorneys' fees, related to cost of collecting unreimbursed amounts; (B) the Trustees, in their sole discretion, may require the Covered Person to pay interest at the rate determined by the Trustees from the date the conditional benefit payments were made through the date that the Fund is reimbursed in full; and (C) the Covered Person waives any applicable statute of limitations defense available regarding the enforcement of the Covered Person's obligation to reimburse the Fund.
- (2) *Offset.* The Fund may recover the full amount of the conditional benefit payments made to or on behalf of the Covered Person by treating such benefits as an advance and deducting such amounts from benefits which become due to the Covered Person and/or to the Covered Person's immediate family members until the conditional benefit payments are recovered. Such benefits may be deducted from amounts due to third parties who have provided medical services despite any certification of coverage which the Plan may have given to such Providers.
- (3) *Any Other Action.* In addition to the remedies set forth herein, the Fund may take any other action it deems appropriate to recover the full amount of the conditional benefit payments made to or on behalf of a Covered Person.

(e) Example

Let's assume that a Covered Person was injured in an automobile accident and the other driver may have been at fault. If the Fund made a conditional benefit payment on the Covered Person's behalf in the

amount of \$5,000 due to the injuries resulting from the accident, and the Covered Person recovered any money from the other driver or the other driver's insurance company (by lawsuit, settlement, or otherwise), the Fund would be entitled to receive up to \$5,000 of that money as reimbursement for the claims paid on the Covered Person's behalf.

10.03 SUBROGATION

If a Covered Person incurs an illness or injury for which a third party may be responsible or liable, and the Fund makes one or more conditional benefit payments to or on behalf of the Covered Person, the Fund is not required to participate in any claims the Covered Person may have against the third party. However, the Fund may require the Covered Person to assign his or her claims and any other right of recovery to the Fund so that the Fund may enforce its right to reimbursement. Moreover, by accepting conditional benefit payments from the Fund, the Covered Person authorizes the Fund to elect to pursue any claims arising from the illness or injury in the name of the Covered Person and/or the Fund's name, and to sue, compromise or settle such claims without the approval of the Covered Person to the extent of benefits paid and/or to be paid.

If the Fund invokes its subrogation rights as described in this Section, the Covered Person must cooperate fully with the Fund in connection with any claim brought by the Fund to recover its assigned or subrogated interest. If the Covered Person does not cooperate, or if the Covered Person or anyone acting in his or her interest takes any action which harms the Fund's subrogated interest, the Fund is entitled to cease payment of conditional benefit payments connected to the third-party caused illness or injury and to collect any conditional benefit payments already-made pursuant to Section 10.02(d).

CHAPTER 11—CLAIMS AND APPEALS PROCEDURES

11.01 IN GENERAL

The provisions of this Chapter shall apply to: (a) any claim for (or right to) a benefit under the Plan; and (b) any claim against the Plan or Fund, regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

A “claim” is a request from a claimant or a claimant’s authorized representative for payment of benefits from the Fund made in accordance with the Fund’s procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered claims. A request for a determination of whether an individual is eligible for benefits under the Plan is not considered a claim; however, if a claimant files a claim for specific benefits and the claim is denied because the individual is not eligible for benefits under the Plan, the coverage determination is considered a claim.

A claim is considered filed as soon as a written claim form is received at the correct address (see following pages) by mail. Telephone calls and e-mails are not acceptable. Filing an incomplete claim or filing a claim at the wrong address may delay payment. Properly completed claims must be accompanied by a bill from the provider and such other proof as may be required by the Fund.

Decisions regarding whether to grant or deny all or part of a claim will be made by the Fund. The term Fund, as defined in Chapter 1 of this Plan, includes a designated agent of the Fund. Both in determining initial claims and in deciding appeals, the Fund will make all determinations in accordance with the applicable Plan documents, policies and rules, and will apply such provisions consistently, to the extent reasonable, with respect to similarly situated claimants.

In determining eligibility for any benefit, the Fund has the right to have the person for whom the benefits are claimed examined by a professionally qualified practitioner designated and paid for by the Fund (e.g., Physician, dentist, etc.). Such examination may be repeated as often as may be reasonably required while the claim is pending. The Fund also has the right to conduct an autopsy, if not forbidden by law or court order, to be performed in case of death.

Throughout the procedures set forth below, there are time limits within which a claimant must file a claim or appeal and within which the Fund must issue a decision on the claim or appeal. The Fund may agree to extend the time limits within which the claimant must file and the claimant may agree to extend any time limit within which the Fund must issue a decision. The agreement to extend a time limit must be knowing, explicit, and confirmed in writing before the time period in question expires.

11.02 WHERE TO FILE

Claims for benefits available under the Plan must be filed with the correct address as follows:

(a) Medical Claims

Independence Blue Cross Claims Receipt Center
P.O. Box 211184
Eagan, MN 55121

In the case of an Out-of-Network claim, no claim will be payable unless an itemized statement is received by the Fund within 20 days from the date the Covered Expense was Incurred. Failure to submit an itemized statement within that time will neither invalidate nor reduce a claim if it can be shown that it was not reasonably possible to furnish the itemized statement within that time and that the claim was submitted

as soon as reasonably possible. However, in no event shall a claim be considered for payment after one year from the date Covered Expense was Incurred.

(b) Prescription Drug Claims

Express Scripts
P.O. Box 14711
Lexington, KY 40512

(c) Dental Claims

Delta Dental
P.O. Box 2105
Lexington, KY 40512

(d) Vision Claims

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

(e) Death / Accidental Death & Dismemberment Claims

Bricklayers & Allied Craftworkers Health & Welfare Fund
2704 Black Lake Place
Philadelphia, PA 19154

11.03 RIGHT TO AN AUTHORIZED REPRESENTATIVE

A claimant has the right to appoint an authorized representative to act on his behalf for the purposes of filing a claim and seeking a review of a denied claim. In order to appoint an authorized representative (this person may be an attorney, but need not be), the claimant must designate the representative in writing. By law, the Plan cannot disclose to a claimant's representative any Protected Health Information (PHI) unless the claimant authorizes the disclosure of PHI to his representative by signing a written authorization and submitting it to the Fund. You may request these forms from the Fund Office.

11.04 APPLICABLE DEFINITIONS

In order to understand how your claim or appeal will be processed, it is important you understand how the Fund categorizes claims. A definition or explanation of each category the Fund will use is set forth below.

(a) Urgent Care Claim

An Urgent Care Claim is a Pre-Service Claim that: (1) involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health, or ability to regain maximum function; or (2) which a Physician with knowledge of your medical condition thinks would subject you to severe pain if your claim were not dealt with in the "urgent care" time frame described in this Chapter. Whether your claim is one involving urgent care will be determined by an individual acting on behalf of the Fund, applying an average layperson's knowledge of health and medicine. If a Physician with knowledge of your medical condition determines that your claim is one involving urgent care, the Fund will treat your claim as an Urgent Care Claim.

(b) Pre-Service Claim

This is any claim for a benefit for which pre-approval of the benefit is required by the Fund before medical care is obtained.

(c) Post-Service Claim

This is any claim for a benefit that is not a Pre-Service Claim. In the case of a Post-Service Claim, you request reimbursement after medical care has already been rendered. Most claims you submit will be Post-Service Claims.

(d) Concurrent Care Claim

This is any claim to extend an ongoing course of treatment beyond the period of time or number of treatments that the Fund has already approved. A Concurrent Care Claim can be either an Urgent Care Claim, a Pre-Service Claim, or a Post-Service Claim.

(e) Incomplete Claim

A claim will be deemed incomplete if you do not provide enough information for the Fund to determine whether and to what extent your claim is covered by the Plan. This includes, but is not limited to, your failure to communicate to a person who ordinarily handles benefit matters for the Fund your name, your specific medical conditions or symptom, and the specific treatment or service for which you request approval.

(f) Disability Claims

Disability Claims, which include claims relating to ongoing eligibility while disabled, will generally be handled like Post-Service Claims for medical benefits; however, there are special rules for disability claims that may be found in Section 11.10 of this Chapter.

(g) Death or AD&D Benefit Claim

This is a claim for benefits made available under Chapter 8 (“Death / Accidental Death & Dismemberment Benefits”).

(h) Rescission

A rescission is a retroactive cancellation or termination of your coverage for reason other than fraud, intentional misrepresentation of material fact, or failure to pay a required premium. A prospective termination of coverage is not a rescission. Termination of coverage for failure to pay a required premium is not a rescission. Additionally, termination of coverage retroactive to the date of divorce is not a rescission if COBRA is not elected and/or the full COBRA premium is not paid by you or your Eligible Dependent(s). A rescission is a benefit claims decision that you have the right to appeal. If your coverage was rescinded for a reason other than fraud, intentional misrepresentation of material fact or failure to pay a premium, your coverage under the Plan will continue during the appeal period.

11.05 TIMEFRAMES FOR MAKING INITIAL CLAIM DECISIONS

(a) Pre-Service Claims

For properly submitted Pre-Service Claims, the claimant will be notified in writing of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Fund. If an extension is necessary, the claimant will be notified before the end of the initial 15-day period of the circumstances requiring the extension and the date by which the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from the claimant on an Incomplete Claim, the extension notice will specify the information needed. In that case, the claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be denied. During the period in which the claimant is allowed to

supply additional information, the normal period for making a decision on the claim will be suspended from the date of the extension notice until either the passage of 45 days or the date the claimant responds to the request, whichever is earlier.

(b) Urgent Care Claims

Urgent Care Claims must be submitted in the same manner as Pre-Service Claims. For properly filed Urgent Care Claims, the claimant will be notified of a decision in writing or by telephone as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim. If the claimant is notified by telephone, the determination will also be confirmed in writing not later than 3 days after the telephone notification.

If an Urgent Care Claim is an Incomplete Claim, the claimant will be notified as soon as possible, but not later than 24 hours after receipt of the Incomplete Claim, of the specific information necessary to complete the claim. The claimant must provide the specified information within 48 hours from receipt of the notification to supply the requested information. If the information is not provided within that time, the claim will be denied.

During the period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either the passage of 48 hours from receipt of the request to supply additional information or the date the claimant responds to the request, whichever is earlier. Notice of the decision will be provided no later than 48 hours after receipt of the specified information or the end of the 48-hour period given for the claimant to provide this information, whichever is earlier.

(c) Concurrent Care Claims

A reconsideration of a benefit with respect to a Concurrent Claim that involves a termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made as soon as possible, but in any event early enough to allow the claimant to have an appeal decided before the benefit is reduced or terminated.

Any request to extend approved urgent care treatment must be submitted in the same manner as Urgent Care Claims. The claimant will be notified of a decision within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. If the claim is not made at least 24 hours prior to the expiration of the approved treatment, the request must be treated as an Urgent Care Claim and decided according to the Urgent Care Claim time frames. A request to extend approved treatment that does not involve urgent care will be decided according to the Pre-Service or Post Service Claim time frames, whichever applies.

(d) Post-Service Claims

For properly filed Post-Service Claims, the claimant will be notified of decisions on Post-Service Claims within 30 days from the receipt of the claim by the Fund. The Fund may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Fund. If an extension is necessary, the claimant will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Fund expects to render a decision.

If an extension is required because the claimant submits an Incomplete Claim, the extension notice will specify the information needed. The claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be denied. During the 45-day period in which the claimant is allowed to supply additional information, the normal

period for making a decision on the claim will be suspended from the date of the extension notice until either the passage of 45 days or the date the claimant responds to the request, whichever is earlier.

(e) Death / AD&D Benefit Claim

A Death / AD&D Benefit claim must be submitted in writing to the insurance carrier designated under Chapter 9 of this Plan. If a Death / AD&D Benefit is denied, in whole or in part, the Fund will provide a written notice of the denial within 90 days after it receives the claim. Should special circumstances require additional time to decide the claim, the Fund will provide a written notice of the extension within 90 days after receipt of the claim explaining the special circumstances and the date by which the Fund expects to render the benefit determination. This extended due date cannot exceed 180 days from the date on which the claim originally was filed.

In the case of a claim for an AD&D benefit, written notice of the event on which the claim is based must be provided to the life insurance carrier designated under Chapter 9 of this Plan no later than 30 days after the loss for which the claim is made. Late notice will be accepted only if it is shown to have been furnished as soon as reasonably possible. Written proof in support of the claim must be provided to the life insurance carrier no later than 90 days after the date of loss for which the claim is made. Late proof will be accepted only if it is shown to have been furnished as soon as reasonably possible.

(f) Disability Claims

The rules for Disability Claims may be found in Section 11.10 of this Chapter

11.06 CONTENT OF INITIAL DENIAL NOTICES

If a claim is denied, in whole or in part, the claimant will be provided written notice of the denial. However, for Urgent Care Claims and Concurrent Claims to extend approved urgent care treatment, the claimant may be notified of denial by telephone, provided that written notice is provided no later than 3 days after telephone notification.

The notice of denial will state, where applicable:

- (a) Specific reason or reasons for the denial or other adverse determination;
- (b) A reference to any pertinent Plan provisions on which the determination is based;
- (c) Any internal rules, guidelines, protocols or other similar criteria relied upon in making the adverse determination or a statement that the claimant is entitled to a copy of such rule, guideline, protocol or other similar criterion, free of charge upon request (not applicable to Death Benefit Claims);
- (d) An explanation of any additional material or information that may be helpful in getting the claimant's claim approved with an explanation why that information is necessary or may be helpful;
- (e) If the adverse determination is based on Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request (not applicable to Death Benefit Claims); and
- (f) The Plan's review procedures and applicable time limits and a statement advising the claimant of his or her right to bring a civil action under ERISA section 502(a).

In the case of an adverse benefit determination concerning an Urgent Care Claim, the notice will also describe the shortened time frames for reviewing Urgent Care Claims.

11.07 YOUR RIGHT TO APPEAL

(a) Time Period in Which to Appeal

If a claim is denied, in whole or in part, or if a claimant disagrees with the decision made on a claim, the claimant or his authorized representative may ask for the benefit denial to be reviewed. To be reviewed, a claimant's written appeal must be filed in a timely manner:

- (1) Generally, claimants have 180 days from the day they received notice of the initial decision to appeal. However, in the case of a Concurrent Care Claim that involves the termination or reduction of previously approved care, the appeal must be completed before the care is terminated or reduced.
- (2) In the case of an Urgent Care Claim, a claimant may request, orally or in writing, immediate review of an adverse determination. Communications between the claimant (or claimant's authorized representative) and the Fund Office may be made by telephone, facsimile, or other similar means.
- (3) In the case of a Death Benefit Claim, the claimant has 90 days from the day he received notice of the initial decision to appeal.

(b) Content of Your Appeal

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial and the reasons for the appeal. You should also submit any documents that support your claim. This does not mean that you are required to cite all the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim or why you disagree with a Plan policy, determination or action. The review of your claim will take into account all comments and documents that support your position, even if the Plan did not have this information when making its initial determination. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

(c) Where to File Your Appeal

Your appeal should be filed at the following address:

Board of Trustees
Bricklayers and Allied Craftworkers Local 1 of PA/DE Health & Welfare Fund
c/o Maria Morris, Fund Administrator
2704 Black Lake Place
Philadelphia, PA 19154
P: (215) 856-9663

(d) Review Process

A claimant has the right, upon request, to receive reasonable access to and copies of all documents relevant to his claim. A document, record or other information is relevant if:

- (1) It was relied upon by the Fund in making the decision;
- (2) It was submitted, considered or generated in the course of making the benefit determination (regardless of whether it was relied upon);
- (3) It demonstrates compliance with the administrative processes for ensuring consistent decision making; or
- (4) With respect to claims other than Death Benefit Claims, it constitutes a statement of Fund policy regarding the denied treatment or service.

The review will take into account all comments, documents, records and other information submitted relating to the claim (regardless of whether this information was submitted or considered in the initial benefit determination).

The following administrative procedures are applicable to all claims other than Death Benefit Claims:

- (1) Upon request, the claimant will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund for the initial determination of the claim, without regard to whether the advice was relied upon in deciding the claim.
- (2) A person other than the person who originally denied a claim will review the claim on appeal. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted.
- (3) If a claim was denied, in whole or in part, on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary or was Experimental/ Investigational), a health care professional who has appropriate training and experience in a relevant field will be consulted.

(e) Failure to File a Timely Appeal

Failure to file a timely appeal will result in a complete waiver of your right to appeal and the Fund's determination regarding the claim will be final.

11.08 TIMING OF NOTIFICATION OF DECISION ON APPEAL

(a) Pre-Service Claims

A notice of a decision on review will be sent within 30 days of receipt of the appeal.

(b) Urgent Care Claims

A notice of a decision on review will be sent within 72 hours of receipt of the appeal by the Fund.

(c) Concurrent Care Claims

A notice of a decision on review for a Concurrent Care Claim that involves termination or reduction of previously approved care will be sent before the care is terminated or reduced. Notice of a decision on review on a Concurrent Care Claim that involves an extension of care will be sent based on the time frames for Urgent Care, Pre-Service or Post-Service Claim, whichever category applies to the appeal.

(d) Post-Service Claims and All Other Claims

Ordinarily, decisions on appeals involving Post-Service Claims and all other claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of the request for review. However, if a request for review is received within 30 days of the next regularly scheduled meeting, the request for review will be considered at the second regularly scheduled meeting following receipt of the request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of request for review may be necessary. The claimant will be advised in writing in advance if this extension will be necessary. Once a decision on review of the claim has been reached, the claimant will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

11.09 CONTENT OF NOTICE OF DECISION ON APPEAL

If an appeal is denied, in whole or in part, the claimant will be provided with a written notice of the denial. The notice will state:

- (a) The specific reason or reasons for the determination;
- (b) Reference to any Plan provisions on which the determination is based;
- (c) A statement that the claimant is entitled, upon request, to receive reasonable access to and copies of all documents relevant to the claim free of charge;
- (d) A statement of right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review;
- (e) A statement that if any internal rules, guidelines, protocols or other similar criteria was relied upon in making the adverse determination, it is available upon request at no charge (not applicable to Death Benefit Claims); and
- (f) If the determination was based on Medical Necessity or Experimental/Investigational treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request (not applicable to Death Benefit Claims).

11.10 SPECIAL RULES FOR DISABILITY DETERMINATIONS

(a) Overview

Recent amendments to Department of Labor’s Claims Procedure Regulations establish special procedural requirements for claims and appeals that involve disability determinations. For this Plan, these amendments may impact how the Fund reviews claims or appeals involving disability eligibility determinations.

In general, the claims and appeals procedures set forth in this Chapter for medical claims also apply to Disability Claims except as set forth in this Section.

(b) Timing of Notification for a Claim Involving a Disability Determination

The Fund will notify you whether your claim involving a disability determination is approved or denied in writing within a reasonable period of time, but not later than 45 days after the claim has been received by the Fund. If the Fund needs more time to review the claim for reasons beyond its control, it may take up to an additional 30 days. Should additional time be required, you will be sent a notice of the extension before the initial 45-day period expires specifically explaining the circumstances requiring the extension, the date by which the Fund expects to make a decision, the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information necessary to resolve those issues. If, prior to the end of the first 30-day extension period, the Plan determines that another extension of up to 30 days is needed, it will send a second extension notice in accordance with the preceding sentence before the expiration of the initial 30 day extension.

If an extension is required because you submit an Incomplete Claim, the notice will also describe the information it needs to make a decision. You will have 45 days after receiving this notice to provide the specified information. If the information is not provided within that time, the claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended from the date of the extension notice until either the passage of 45 days or the date you respond to the request, whichever is earlier.

(c) Content of Notification of an Adverse Benefit Determination Relating to Disability

The notification of an adverse benefit determination relating to disability will include the information specified above in Section 11.06 (“Content of Initial Denial Notices”), along with a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views you

presented to the Fund of health care professionals treating you and vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse benefit determination; and (3) if applicable, a disability determination made by the Social Security Administration regarding you.

If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the notification will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The notification will also include: (1) either the specific rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and (2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Such notification shall be provided in a culturally and linguistically appropriate manner.

(d) Special Appeal Procedures for Disability Determinations

In addition to the appeal procedures set forth in this Chapter, in the case of an appeal involving a disability determination, the Fund will, before issuing an adverse benefit determination on appeal, provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund or other person making the benefit determination (or at the direction of the Fund or such other person) in connection with your claim. You will be provided with such evidence 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 you (see “Notification of Disability Decision on Appeal” below) to give you a reasonable opportunity to respond prior to that date.

In addition, before the Fund can issue an adverse benefit determination on appeal based on a new or additional rationale, the Fund will provide you, free of charge, with the rationale. You will be provided with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on appeal is required to be provided to you (see “Notification of Disability Decision on Appeal” below) to give you a reasonable opportunity to respond prior to that date.

(e) Notification of Disability Decision on Appeal

- (1) *Timing of Notification for a Disability Claim.* The Trustees or a designated Committee of the Trustees will review your appeal at their regularly scheduled (at least quarterly) meeting immediately following receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In that case, your appeal will be reviewed at the second meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of time for review for the Trustees, a benefit determination will be rendered not later than the third Trustees meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision. You will receive written or electronic notice of the decision of the Trustees after review by the Trustees, within 5 days of their decision.
- (2) *Content of Notifications for a Disability Claim.* The Fund will provide you with written or electronic notice of its determination on review. The notice will include the information specified above in Section 11.09 (“Content of Notice of Decision on Appeal”), as well as a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views you

presented to the Trustees of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) if applicable, a disability determination regarding the claimant that you presented to the Fund made by the Social Security Administration.

If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the Fund will provide you with either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The Fund's notice will also include: (i) either the specific rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and (ii) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Such notice will be provided in a culturally and linguistically appropriate manner.

11.11 POLICIES, DETERMINATIONS OR ACTIONS

If you disagree with a policy, determination, or action of the Fund, you may request the Board of Trustees to review the policy, determination or action with which you disagree by submitting a written appeal to the Trustees. You must state the reason for your appeal and submit any supporting documentation. Your written appeal must be submitted within 60 days after you learn of the policy, determination or action with which you disagree, which is not a benefits denial. The Trustees will have sole authority and discretion to interpret and apply Plan documents, policies, determinations or actions.

The Board of Trustees will review your appeal at its regularly scheduled meeting immediately following receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second regularly scheduled meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be considered at that meeting. If special circumstances require an extension of the time for review by the Trustees, you will be notified in writing.

11.12 DECISIONS OF THE TRUSTEES ARE FINAL AND BINDING

(a) Decisions are Final and Binding

The Fund's decision on review/appeal shall be final and binding on all parties, including anyone claiming a benefit on your behalf. Except in cases where the Fund determines that reconsideration of your claim or appeal is appropriate, there is no further level of appeal under this Plan. The Trustees may determine that reconsideration of your claim or appeal is appropriate based on new information that was not available at the time of the initial appeal. The Trustees have full authority and discretion to determine if reconsideration is warranted.

(b) Trustee Discretion and Authority

The Trustees have full discretion or authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility and interpretation of the Plan and other policies and rules. The Trustees have full authority and discretion to determine if a benefit is covered or subject to reimbursement under the Plan.

(c) Judicial Review / Limitations Period

If the Trustees deny your appeal or a claim, and you decide to seek judicial review, the Trustees' decision shall be subject to limited judicial review to determine only whether their decision was arbitrary and capricious. Additionally, evidence may not be used in court unless it was first submitted to the Trustees prior to the decision on appeal. Unless contrary to applicable law, no person may seek judicial review of a decision to deny a claim, including any appeal of the claim, more than 3 years after a final appeal is denied. In other words, should the 3 year period referenced in the previous sentence lapse, no legal action may be commenced or maintained against the Fund, the Plan, the Trustees, or anyone acting on their behalf.

CHAPTER 12—IMPORTANT MISCELLANEOUS PROVISIONS

12.01 PLAN INTERPRETATION, AMENDMENT AND TERMINATION

(a) Plan Interpretation / Amendment

The Board of Trustees, in its sole discretion, may interpret, amend, or terminate the Plan and any of its provisions, in whole or in part, at any time. This means that: (1) the Board of Trustees has the exclusive discretionary authority to determine all questions regarding coverage, eligibility, entitlement to benefits and other related matters; (2) all Plan benefits made available to Participants are conditional and subject to the Board of Trustees' exclusive discretionary authority to improve, reduce, eliminate or otherwise modify them; and (3) the Board of Trustees has the exclusive discretionary authority to modify or terminate the Plan's provisions related to classes of coverage, eligibility, the availability, nature and extent of benefits, and the conditions, methods and rates of payment and self-payment.

Interpretations regarding eligibility for benefits, claims, status of Covered Persons or Employers, or any other matter relating to the Plan should only be obtained through the full Board of Trustees or the Fund Office. The Trustees are not bound by, responsible for, or obligated by opinions, information or representations from any other source.

(b) Plan Termination

The Plan can be terminated in the event that either the Union and the Employers signatory to the Trust Agreement, or their designated successors, mutually agree to terminate the Plan or if the Collective Bargaining Agreement between the Union and the Employers expires and there is no reasonable possibility of a successor Collective Bargaining Agreement being negotiated in the foreseeable future under which contributions to the Fund continue.

In the event of Plan termination, the assets of the Plan shall not revert to any Employer but shall be used to defray administrative costs of termination and to thereafter provide such termination benefits to Covered Persons which are consistent with the purposes, intent, and terms of the Trust Agreement.

The Trustees shall notify all Covered Persons of the Plan's termination as soon as administratively feasible but no more than sixty (60) days after the date on which the decision to terminate is made.

12.02 NO VESTING

Benefits made available through the Plan are not guaranteed to Covered Persons. In other words, benefits made available under this Plan are not vested with respect to any individual. Benefits are provided only from the assets of the Fund collected and available to support them, and to the extent the benefits of the Plan are supported by an insurance policy.

As described in the previous paragraphs, the Trustees have the authority to increase, decrease or modify benefits of the Plan as they may find it necessary for the sound and efficient administration of the Fund. All benefits of the Plan are conditional and subject to the Trustees' authority under the Plan and Trust Agreement to change them.

12.03 EXCLUSIVE RIGHT TO BENEFITS

No individual shall have a right to benefits provided under the Plan, except as specified in the Plan. No party may rely on any representations about the meaning of any provision of the Plan or the benefits provided under the Plan that are inconsistent with the terms of the Plan.

12.04 NO ASSIGNMENT OR ATTACHMENT OF BENEFITS

You cannot assign 1) your benefits under the Plan, 2) the right to request information, 3) the right to make a claim or bring an appeal, or 4) the right to file any lawsuit, to any other person or entity, including an Out-of-Network Provider, without the Plan's express written prior consent to permit a specific authorized representative to act on your behalf. Any assignment made without the Plan's express written prior consent will be void, any assignee will not acquire rights by reason of such an assignment, and the Plan will not recognize or accept any such assignment.

The Plan will accept properly submitted claims from Providers on behalf of participants and beneficiaries. The Plan may, in its sole and exclusive discretion and on a case-by-case basis, agree to correspond with or pay Providers directly for services covered by the Plan. Any such communication or payment, however, shall not be construed as a waiver of the Plan's anti-Assignment rule or for any purpose other than for the specific communication or payment made.

All benefits under the Plan are exempt, to the extent permitted by law, from the claims of creditors and from all orders, decrees, garnishments, executions or other legal processes or proceedings. If there has been a benefit overpayment, or you otherwise owe money to the Fund, the Fund may choose to offset the overpayment against future benefits even if you have directed those benefits to your Hospital, Physician or other Provider. This is true even if the Fund has Pre-certified coverage.

12.05 NO LIABILITY FOR PRACTICE OF MEDICINE

The Fund, the Board of Trustees, and their designees are not engaged in the practice of medicine. They do not have control over the health care services provided or delivered to a Covered Person by any Provider, or the diagnosis, treatment, care, or lack thereof with respect to any illness or injury. Using the services of a Provider is a voluntary act regardless of whether such Provider is designated by the Fund or participates in the PPO network. Nothing in this Plan is intended to be a recommendation or instruction to use a particular Provider. You should select a Provider or course of treatment based on all appropriate factors, only one of which is coverage under the Plan. Providers are not employees of the Fund.

The Fund makes no representation regarding the quality of service or treatment rendered by any Provider. The Fund is not responsible for any acts or omissions of any provider in connection with any service or treatment. Neither the Fund, the Board of Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to any Covered Person by any Provider by reason of negligence, failure to provide care or treatment, or otherwise. A Provider is solely responsible for the services and treatments he or she renders.

12.06 WORKERS' COMPENSATION

The benefits provided by the Plan are not in lieu of any coverage mandated under a workers' compensation law or similar statute. This Plan does not provide benefits under circumstances where benefits are payable under a workers' compensation law or similar statute.

12.07 ALLOCATING/DELEGATING TRUSTEE AUTHORITY; ACTIONS IN ACCORDANCE WITH TRUST

To the extent permitted under ERISA, the Trustees may take action in accordance with the terms of the Trust Agreement to allocate and delegate their responsibilities, including fiduciary responsibilities, to others where it is deemed appropriate for the effective operation and administration of the Plan. The Trustees may also take action in accordance with the terms of the Trust Agreement to retain one or more persons to render advice regarding their responsibilities or to designate one or more persons to take such action on their behalf. Finally, in accordance with the terms of the Trust Agreement, the Trustees may appoint one or more investment managers to invest, reinvest and otherwise manage assets of the Plan, including the power to acquire or dispose of such assets. The Trustees may take any other action in accordance with the Trust Agreement as they deem necessary.

12.08 PRESERVATION OF PLAN PROVISIONS

This document supersedes and replaces any previous literature furnished regarding the Plan's benefits and is intended to serve as both the Summary Plan Description and the Plan Document. Should any provision of the Plan be held to be unlawful, or unlawful as to any person or instance, such holding will not, to the extent possible, adversely affect the other provisions contained in the Plan or the application of said provisions to any other person or instance.

12.09 GOVERNING LAW AND FORUM SELECTION CLAUSE

The terms of the Plan are governed by and construed in accordance with federal law to the extent federal law applies. To the extent federal law does not apply, the terms of the Plan will be governed by and construed in accordance with the laws of the State of Pennsylvania. The Trustees have the exclusive discretionary authority to interpret the Plan.

Any legal action under Title I of ERISA brought against the Plan, the Fund, the Board of Trustees, or anyone acting on their behalf must be brought exclusively in the federal courts located within Philadelphia County of the Commonwealth of Pennsylvania, where the Plan is administered, in which case the parties consent and submit to the personal jurisdiction of the federal courts located within Philadelphia County of the Commonwealth of Pennsylvania. Any other legal action brought against the Plan, the Fund, the Board of Trustees, or anyone acting on their behalf must be brought exclusively in the state or federal courts located within Philadelphia County of the Commonwealth of Pennsylvania, where the Plan is administered, in which case the parties consent and submit to the personal jurisdiction of the state or federal courts located within Philadelphia County of the Commonwealth of Pennsylvania.

CHAPTER 13—GENERAL INFORMATION AND YOUR ERISA RIGHTS

13.01 NAME OF THE PLAN

The name of the Plan is the Bricklayers and Allied Craftworkers Local 1 of PA/DE Health and Welfare Fund.

13.02 PLAN ADMINISTRATION

The Fund is a collectively bargained trust fund administered by a joint Board of Trustees. The Plan is self-insured. The Board of Trustees is the Administrator of the Plan as defined by ERISA.

The Trustees have delegated the day-to-day administration of the Plan to:

Maria Morris
2704 Black Lake Place
Philadelphia, PA 19154
P: (215) 856-9663

The names and business addresses of the Trustees are:

UNION TRUSTEES

Dennis J. Pagliotti
Bricklayers and Allied Craftworkers Local 1 of PA/DE
2706 Black Lake Place
Philadelphia, PA 19154

Joseph J. Battaglia
Bricklayers and Allied Craftworkers Local 1 of PA/DE
2706 Black Lake Place
Philadelphia, PA 19154

Donald Anderson
Bricklayers and Allied Craftworkers Local 1 of PA/DE
2706 Black Lake Place
Philadelphia, PA 19154

Dale Douglas
Bricklayers and Allied Craftworkers Local 1 of PA/DE
2706 Black Lake Place
Philadelphia, PA 19154

Justin Scarinci
Bricklayers and Allied Craftworkers Local 1 of PA/DE
2706 Black Lake Place
Philadelphia, PA 19154

Rick Tulowitzki
Bricklayers and Allied Craftworkers Local 1 of PA/DE
706 Liberty Boulevard
New Castle, DE 19720

EMPLOYER TRUSTEES

Amy Hennessey, Executive Director
Employing Bricklayers Association
1375 Virginia Dr., Suite 101
Ft. Washington, PA 19034

Chris Claudy
Suburban Enterprises Terrazzo & Tile Co.
206 Kirkbrae Road
Kennett Square, PA 19348

Mark Cannon
Giles Cannon, Inc.
600 Pusey Avenue
Collindale, PA 19023

Nick Sabia
D. M. Sabia & Co.
P.O. Box 112
Conshohocken, PA 19428

Dave Crawford
Crawford Caulking
1927 Stout Drive, #1
Warminster, PA 18974

Mark Rizzo
Joseph Rizzo & Sons
12 Rizzo Avenue, Rosehill
New Castle, DE 19720

13.03 NAME OF PLAN SPONSOR

The Plan Sponsor of the Plan is the Board of Trustees of the Bricklayers and Allied Craftworkers Local 1 of PA/DE Health and Welfare Fund.

13.04 AGENT FOR SERVICE OF LEGAL PROCESS

The designated agent of the Fund for service of legal process is Maria Morris. In addition, service of legal process may be made upon the Board of Trustees at the Fund Office.

13.05 PLAN NUMBER AND EMPLOYER IDENTIFICATION NUMBER (EIN)

Plan Number: 001

EIN: 23-2892285

13.06 TYPE OF PLAN

The Plan is a welfare benefit plan providing medical, hospital, prescription drug, dental, vision, disability, death and other related benefits.

13.07 PLAN YEAR

May 1 through April 30. For purposes of determining a Covered Person's annual Deductible and all other benefit-related limitations and maximums, the calendar year is used.

13.08 SOURCE OF FINANCING

The Plan is funded by contributions made by individual Employers under the provisions of Collective Bargaining Agreements, by self-payments by Employees and Retirees in accordance with the provisions of this Plan, and any income earned from investment of such contributions and payments.

The Plan assets are maintained and managed in custodial accounts at Amalgamated Bank, 275 Seventh Avenue, New York, NY 10001. All monies are used exclusively to provide benefits to Covered Persons, and to pay all expenses incurred with respect to the operation of the Plan. The Trustees periodically review the funding status of the Plan.

Plan participants and beneficiaries may receive from the Fund Office, upon written request, information as to whether or not a particular Employer is a contributing Employer and any applicable Collective Bargaining Agreement.

13.09 SERVICE PROVIDERS

The Plan has contracted with various organizations to provide certain services to participants. These services are provided for as long as the Plan contracts with them and may be terminated by the Plan. These services include:

(a) Medical and Hospitalization Benefits / Preferred Provider Organization (PPO)

Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103-1480

(b) Prescription Benefit Manager (PBM)

Express Scripts, Inc.
400 Market Street, 10th Floor, Suite 1025
Philadelphia, PA 19106

(c) Vision Care Coverage

Davis Vision

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

(d) Dental Benefits

Delta Dental of Pennsylvania
P.O. Box 2105
Mechanicsburg, PA 17055

(e) Life Insurance and Accidental Death Benefits

Amalgamated Life Insurance Company
333 Westchester Ave, # N101
West Harrison, NY 10604

(f) Third-Party Participant Advocate

Guardian Nurses Healthcare Advocates
P.O. Box 224
Flourtown, PA 19031
215-836-0260

(g) Alcohol or Drug Abuse and Dependency PPO

Allied Trades Assistance Program (ATAP)
4170 Woodhaven Road
Philadelphia, PA 19154
800-258-6376

13.10 COMPLIANCE WITH PRIVACY STANDARDS

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("Privacy Rules"). Under these standards, the Plan will protect the privacy of individually identifiable health information and will block or limit the disclosure of this information to the Trustees, Employers, the Union, your family members, service providers and other third parties. Protected Health Information ("PHI") will be disclosed only (1) to the extent authorized by the patient; (2) as necessary for the administration of the Plan, including the review and payment of claims and the determination of appeals; or (3) as otherwise authorized or required by law.

You may authorize the disclosure of your PHI to third parties by signing a written authorization and submitting it to the Fund Office. You may also cancel any previous written authorization you have provided the Fund by submitting a written cancellation of authorization with the Fund Office. You may request these forms from the Fund Office.

The Fund has provided Covered Persons with a Notice of Privacy Practices for Protected Health Information. If you need a copy of the Notice or would like additional information about the Plan's use and disclosure of PHI or your rights with regard to this information, you may request a copy of the Notice from the Fund Office.

You will likely receive separate Privacy Notices and forms from the Plan's other service providers if these entities must use or disclose PHI. If you have any questions about those Notices or forms, you may contact the service provider, as applicable, or you may call the Fund Office.

13.11 YOUR RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

(a) Receive Information About Your Plan and Benefits

Examine, without charge, at the Fund Administrator's office 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.

Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and the updated summary plan description. The Fund Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.

(b) Continue Group Health Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. This document includes the rules governing your COBRA continuation coverage rights.

(c) Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

(d) Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation for the reason for the denial. You have the right to have the Fund review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Fund 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 Fund 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. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Fund Administrator

(e) Assistance with Your Questions

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, 1730 K Street, N.W., Washington, D.C. 20006, (866) 444-EBSA (3272) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and

responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

13.12 WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Group health plans and health insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Pursuant to the Women's Health and Cancer Rights Act of 1998, surgical expenses shall include reconstructive surgery and post surgical scar correction following a mastectomy. Reconstructive surgery following a mastectomy includes reconstruction of the breast in which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearances; and prostheses. Coverage is also provided for physical complications at all states of mastectomy, including lymph edemas.

13.13 GRANDFATHERED PLAN DISCLOSURE

The Board of Trustees of the Plan believes it is a "Grandfathered Health Plan" under PPACA. As permitted by PPACA, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when PPACA was enacted. Being a Grandfathered Health Plan means that this Plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Maria Morris, 2704 Black Lake Place, Philadelphia, PA 19154, 215-856-9663. You may also contact the Employee Benefits Services Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.