TEAMSTERS LOCAL UNION 966

HEALTH FUND

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

(January 1, 2018)

Revised August 1, 2019

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ADOPTION

The Trustees of the Teamsters Local Union 966 Health Fund ***(Trustees)*** have caused this restated Teamsters Local Union 966 Health Plan ***(Plan)*** to take effect as of the first day of January 2018. This is a revision of the Plan previously adopted January 1, 2009. We have read the document herein and certify the document reflects the terms and conditions of the Employee welfare benefit Plan as established by the ***Trustees***.

Union Trustee

_____
James R. Anderson

Employer Trustee

_____
John O'Meara, Jr.

DATE: _____

SUMMARY PLAN DESCRIPTION

Name of Plan
Teamsters Local Union 966 Health Fund

Name, Address, and Phone Number of Plan Sponsor
Trustees of the Teamsters Local Union 966 Health Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(888) 490-8800

Employer Identification Number
13-1911036

Plan Number
501

Type of Plan
Welfare Benefit Plan: burial, medical, dental, prescription drug, and vision benefits.

Type of Administration
Contract administration: The processing of claims for benefits under the terms of the ***Plan*** is provided through a company contracted by the ***Trustees*** and shall hereinafter be referred to as the ***Third-Party Plan Administrator (TPA) or claims processor.***

Name, Address, and Phone Number of *Party Plan Administrator* and Agent For Service of Legal Process
Benesys, Inc.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
(888) 490-8800

Legal process may be served upon the ***Third-Party Plan Administrator*** or the ***Trustees***.

Name, Title, Address, and Principal Place of Business for the *Trustees*
Union Trustee

James R. Anderson
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Employer Trustee

John O'Meara, Jr.
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

Health Fund
This Health Fund has been established pursuant to collective bargaining agreements between Local Union 966 of the International Brotherhood of Teamsters and several ***Employers***. The Health Fund provides benefits for ***Employees*** covered under the collective bargaining agreements. In addition, certain non-bargaining ***Employees*** of the Union and the ***Employers*** are also provided benefits by the Health Fund. ***Employees*** have a right to obtain a copy of the

collective bargaining agreement. A written request for such copy should be submitted to the ***Third-Party Plan Administrator.*** The collective bargaining agreement is available for examination in the ***Third Party Plan Administrator 's*** office.

Reservation of Rights
Plan benefits for participants are not guaranteed. The ***Trustees*** reserve the right to change or discontinue (1) the types and amounts of benefits under this ***Plan*** and (2) the eligibility rules, including those rules providing extended or accumulated eligibility even if extended eligibility has already been accumulated. The nature and amount of plan benefits and eligibility rules are always subject to the actual terms of the ***Plan*** as it exists at the time the claim occurs. The ***Trustees*** have the sole and exclusive right and discretion to interpret the ***Plan***, its rules and regulations, as to eligibility, the types and extent of benefits provided, administrative procedures, and all other provisions set forth herein.

Eligibility Requirements
For detailed information regarding a person's eligibility to participate in the ***Plan,*** refer to the following sections:

Eligibility
Enrollment
Effective Date of Coverage

For detailed information regarding a person being ineligible for benefits through reaching ***maximum benefit*** levels or ***termination of coverage,*** refer to the following sections:

Schedule of Benefits
Effective Date of Coverage
Termination of Coverage
Plan Exclusions

Source of Plan Contributions
Contributions for ***Plan*** expenses are obtained from the ***Employers*** and from the covered ***Employees.*** The ***Trustees,*** working with the ***Third-Party Plan Administrator*** and their advisors**,** evaluate the costs of the ***Plan*** based on projected ***Plan*** expenses, and they determine the recommended amount to be contributed by the ***Employers*** and the amount to be contributed by the covered ***Employees,*** if any**.**

Funding Method
The ***Trustees*** will maintain a trust for the receipt of money and property to fund the ***Plan,*** for the management and investment of such funds, and for the payment of ***Plan*** benefits and expenses from such funds.

The ***Trustees*** shall deliver, from time to time to the trust, amounts of money and property as shall be necessary to provide the trust with sufficient funds to pay all ***Plan*** benefits and reasonable expenses of administering the ***Plan*** as the same shall be due and payable. The ***Trustees*** may provide for all or any part of such funding by insurance issued by a company duly qualified to issue insurance for such purpose and may pay the premiums, therefore, directly or by funds deposited in the trust.

All funds received by the trust and all earnings of the trust shall be applied toward payment of ***Plan*** benefits and reasonable expenses of administration of the ***Plan*** except to the extent otherwise provided by the ***Plan*** documents. The ***Trustees*** may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the ***Plan.***

Covered persons shall look only to the funds in the Trust for payment of ***Plan*** benefits and expenses.

Ending Date of Plan Year
December 31st

Procedures for Filing Claims
For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Claim Filing Procedure.*

The designated ***claims processors*** are:

BeneSys
MagnaCare
Envision RxOptions
Administrative Services Only, Inc

Statement of ERISA Rights
As a participant in the Teamsters Local Union 966 Health Fund, the participant is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About The Plan and Benefits

Examine, without charge, at the ***Third-Party Plan 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 and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the ***Third-Party Plan 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 updated Summary Plan Description. The ***Third-Party Plan Administrator*** may make a reasonable charge for the copies.

Receive a summary of the ***Plan's*** annual financial report. The ***Third-Party Plan Administrator*** is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

Continued health care coverage may be provided for the ***Employee***, spouse, or ***dependents*** if there is a loss of coverage under the ***Plan*** as a result of a qualifying event. The ***Employee*** or his or her ***dependents*** may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing the COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforcing Rights

If a claim for a health benefit is denied or ignored, in whole or in part, the ***covered person*** has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a ***covered person*** can take to enforce the above rights. For instance, if the ***covered person*** requests a copy of ***Plan*** documents or the latest annual report from the ***Plan*** and does not receive them within thirty (30) days, the ***covered person*** may file suit in a Federal court. In such a case, the court may require the ***Third-Party Plan Administrator*** to provide the materials and pay the ***covered person*** up to one hundred ten dollars ($110) a day until the ***covered person*** receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If the ***covered person*** has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a state or Federal court. In addition, if the ***covered person*** disagrees with the ***Plan's*** decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the ***covered person*** may file suit in Federal court. If it should happen that ***Plan*** fiduciaries misuse the ***Plan's*** money, or if the ***covered person*** is discriminated against for asserting his or her rights, they may seek assistance from the U.S. Department of Labor, or they may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the ***covered person*** is successful, the court may order the person they have sued to pay these costs and fees. If the ***covered person*** loses, the court may order them to pay these costs and fees, for example, if it finds the claim is frivolous.

Assistance with Questions

If the ***covered person*** has any questions about this ***Plan***, they should contact the ***Third-Party Plan Administrator***. If the ***covered person*** has any questions about this statement or about their rights under ERISA, or if they need assistance in obtaining documents from the ***Third-Party Plan Administrator***, they should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory 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. The ***covered person*** may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Conformity With Applicable Laws

This ***Plan*** shall be deemed to automatically be amended to conform as required by any applicable law, regulation, or the order or judgment of a court of competent jurisdiction governing provisions of this ***Plan,*** including, but not limited to, stated maximums, exclusions, or limitations. In the event that any law, regulation, or the order or judgment of a court of competent jurisdiction causes the ***Third-Party Plan Administrator*** to pay claims which are otherwise limited or excluded under this ***Plan,*** such payments will be considered as being in accordance with the terms of this ***Plan*** document. It is intended that the ***Plan*** will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable laws.

HIPAA PRIVACY STATEMENT

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The ***Plan*** will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the ***Plan*** will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

"Payment" includes activities undertaken by the ***Plan*** to obtain premiums or determine or fulfill its responsibility for coverage and provision of ***Plan*** benefits that relate to a ***covered person*** to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and coinsurance amounts (for example, cost of a benefit or ***Plan*** maximums as determined for a ***covered person's*** claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing ***Employee*** contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities, and related health care data processing;
- Claims management and related data processing, including auditing payments, investigating and resolving payment disputes, and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
- Medical necessity reviews or reviews of appropriateness of care or justification of charges;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement; and
- Reimbursement to the ***Plan.***

"Health Care Operations" include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives, and related functions;
- Rating provider and ***Plan*** performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and creating, securing, or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Business Planning and development, such as conducting cost-management and Planning-related analyses related to managing and operating the ***Plan,*** including formulary development and administration, development or improvement of payment methods, or coverage policies;
- Business management and general administrative activities of the ***Plan***, including, but not limited to:
  (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or

(b) customer service, including the provision of data analysis for policyholders, Plan sponsors, or other customers;

- Resolution of internal grievances.

THE PLAN WILL USE AND DISCLOSE PHI TO THE THIRD-PARTY PLAN ADMINISTRATOR AND AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE COVERED PERSON

With an authorization, the ***Plan*** will disclose PHI to other health benefit Plans, health insurance issuers, or HMOs for purposes related to the administration of these Plans.

The Plan will disclose PHI to the ***Third-Party Plan Administrator*** only upon receipt of a certification from the ***Third-Party Plan Administrator*** that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the ***Third-Party Plan Administrator*** agrees to certain conditions.

The ***Third-Party Plan Administrator*** agrees to:

- Not use or further disclose PHI other than as permitted or required by the ***Plan*** document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the ***Third-Party Plan Administrator*** provides PHI received from the ***Plan*** agree to the same restrictions and conditions that apply to the ***Third-Party Plan Administrator*** with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by a ***covered person****;*
- Not use or disclose PHI in connection with any other benefit or Employee Benefit Plan of the ***Third-Party Plan Administrator*** unless authorized by the ***covered person****;*
- Report to the ***Plan*** any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to a ***covered person*** in accordance with HIPAA's access requirements***;***
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books, and records relating to the use and disclosure of PHI received from the ***Plan*** available to the Health and Human Services Secretary for the purpose of determining the ***Plan's*** compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the ***Plan*** that the ***Third-Party Plan Administrator*** still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the ***Third-Party Plan Administrator*** on behalf of the ***Plan***. Specifically, such safeguarding entails an obligation to:
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    1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that the ***Third-Party Plan Administrator*** creates, receives, maintains, or transmits on behalf of the ***Plan****;*
    2. Ensure that the adequate separation as required by 45 C.F.R. 164-504(f)(20)(iii) is supported by reasonable and appropriate security measures;
    3. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
    4. Report to the ***Plan*** any security incident of which it becomes aware**.**

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Utilization Review, Medical Expense Benefit, Prescription Drug Program, Dental Expense Benefit, Vision Expense Benefit, Plan Exclusions,* and *Preferred Providers.*

MEDICAL BENEFITS

Maximum Benefit Per Covered Person While Covered By This Plan

Medical	No Maximum

Calendar Year Deductible: (*Preferred Providers)*

Individual Deductible (Per Person)	$1,000
Family Deductible (Aggregate)	No Maximum Family Deductible

Calendar Year Deductible: (applies to *non-preferred providers*)

Individual Deductible (Per Person)	$1,500
Family Deductible (Aggregate)	No Maximum Family Deductible

Out-of-Pocket Medical and Prescription Expense Limit Per Calendar Year (applies only to *preferred providers*)

	Prescription	Medical
Individual (Per Person)	$1,850	$5,500
Family	$3,700	$11,000

Refer to *Medical Expense Benefit, Calendar Year Out-of-Pocket Medical Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.

Coinsurance

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year and, for the services of ***preferred providers*** and ***non-preferred providers,*** after the individual or family deductible has been satisfied and until the individual out-of-pocket medical expense limit has been reached. Thereafter, for the services of ***preferred providers*** the ***Plan*** pays one hundred percent (100%) of ***incurred covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Medical Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance.***

Benefit Description	***Preferred Provider***	***Non-preferred Provider***
Inpatient Hospital	70%	50% no deductible
Emergency Room Services	100%	50% no deductible
Outpatient Hospital Services	70% after deductible	50% after deductible
Physician's Services		
Office Visit (including x-rays and lab)	70% after deductible	50% after deductible

Inpatient Visit	70% after deductible	50% after deductible
Surgery	70% after deductible	50% after deductible
Second Surgical Opinion	70% after deductible	50% after deductible
Anesthesiology	70% after deductible	50% after deductible
Diagnostic X-rays & Lab Inpatient	70% after deductible	50% after deductible
Outpatient	70% after deductible	50% after deductible
Durable Medical Equipment	70% after deductible	50% after deductible
Well Child Care & Immunizations Limitation: through age 2 (age 18 for immunizations)	100%	100% no deductible
Routine Physical Examination	100%	no coverage
Routine Mammograms	100%	50% after deductible
Extended Care Facility Limitation: 120 days ***maximum benefit*** per confinement	100%	50% after deductible
Hospice Services Limited to 45 days (aggregate)	70%	Not Covered
All Other Covered Expenses	70% after deductible	50% after deductible

PRESCRIPTION DRUG PROGRAM

Participating Pharmacy - Prescription Drug Card	100% after ***co-pay***;
Co-pay	Generic: $25 ***co-pay*** Preferred Brand Name: $40 ***co-pay*** Non-Preferred Brand Name: $65 ***co-pay*** Non-Preferred Brand Name: $115 ***co-pay***

Note: The generic cost may be less than $25 based upon the participating pharmacy's agreed upon discount.

Limitations: 30-day supply. Any medication available "over the counter" *including* non-sedating antihistamines (NSAs) and proton pump inhibitors (PPIs) are not covered under the Prescription Drug Program for the Fund. If the ***covered person*** purchases a brand name drug for which there is a generic bio-equivalent, the ***covered person*** will be required to pay the difference between the cost of the ***generic*** drug and the brand name requested, plus the usual ***generic co-pay.***

Mail Order Prescriptions	100% after ***co-pay***;
Co-pay	Generic: $35 ***co-pay*** Preferred Brand Name: $65 ***co-pay*** Non-Preferred Brand Name: $115 ***co-pay***

Limitations: 90-day supply. Any medication available "over the counter" *including* non-sedating antihistamines (NSAs) and proton pump inhibitors (PPIs) are not covered under the Prescription Drug Program for the Fund. If the ***covered person*** purchases a brand name drug for which there is a generic bio-equivalent, the ***covered person*** will be required to pay the difference between the cost of the ***generic*** drug and the brand name requested, plus the usual ***generic co-pay.***

DENTAL BENEFITS

Calendar Year Deductible	
Individual Deductible (Per Person)	$100
Maximum Benefit Per Covered Person	
Covered Dental Allowances, per calendar year (other than Orthodontics)	
Per Person	$1,500
Customary and Reasonable Amount Payable For:	
Covered Dental Allowances	per schedule
Orthodontic Services	no coverage provided

VISION BENEFITS

Examination, Lenses, and Frames	
Maximum benefit per person per calendar year (Adult)	$200
Maximum benefit per person per calendar year (Pediatric)	No Maximum for PediatricVision Benefits*

*Refer to page 45 for frequency and permissible lens/material benefits under Pediatric Vision

BURIAL BENEFITS

Gravesite at Forest Park Green Cemetery, Morganville, NJ
For Employee and Spouse (parent or child if unmarried)

SCHEDULE OF BENEFITS

Metropolitan Reclamation Services, Inc. ***(Grandfathered Employees)***

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Utilization Review, Medical Expense Benefit, Prescription Drug Program, Metropolitan Reclamation Services Grandfathered Employees Dental Benefit, Vision Expense Benefit, Death Benefit, Plan Exclusions,* and *Preferred Providers.*

MEDICAL BENEFITS

Maximum Benefit Per Covered Person While Covered By This Plan:

Medical **No Maximum***

*A 20 visit limit per person per calendar year applies to the following specific covered services: chiropractic, physical therapy, and occupational therapy visits.

Calendar Year Deductible:

	In-Network	Out-of-Network
Individual Deductible (Per Person)	$200	$300
Family Deductible (Aggregate)	$300	$700

Out-of-Pocket Medical and Prescription Expense Limit Per Calendar Year: (applies only to In-Network)

	Hospital & Major Medical	Prescription
Individual (Per Person)	$1,000	$5,850
Family	$2,000	$11,700

Premiums, health care this Plan does not cover, out-of-network coinsurance, and penalties for failure to pre-certify are not included in the out-of-pocket limit.

Copay and Coinsurance:
The information below indicates the participant's cost for the services of ***participating providers*** and ***non-participating providers.***

Benefit Description	***Preferred Provider***	***Non-Preferred Provider***
Outpatient Surgery		
Physician/Surgeon Fee	$15 copay/visit	25% coinsurance
Facility Fee (ambulatory surgery center)	$100 copay* 0% coinsurance	50% coinsurance**

** $100 copay is waived if you are admitted to an in-network provider.*
*** Payment limited to 50% of reasonable and customary charge of CPT code for surgery performed for non-network facilities; 25% of each additional procedure. Certain procedures require pre-authorization.*

Inpatient Hospital		
Physician/Surgeon Fee	$15 copay	25% coinsurance
Facility Fee (hospital room)	0% coinsurance*	25% coinsurance
**Deductible does not apply in-network.*		
Emergency Services		
Emergency Room Services	0% coinsurance*	25% coinsurance**
$100 copay applies for in-network services.* * No deductible for out-of-network providers.*		
Emergency Medical Transportation *Deductible does not apply.*	0% coinsurance	25% coinsurance
Urgent Care	$15 copay/visit	25% coinsurance
Physician's Services		
Primary Care Office Visit (injury or illness)	$15 copay/visit	25% coinsurance
Specialist Visit	$15 copay/visit	25% coinsurance
Other Practitioner Visit (*Refer to visit limits noted under Medical Benefits*)	$15 copay/visit	25% coinsurance*
Preventative Care/Screening/Immunization	no charge	25% coinsurance
Mental Health, Behavioral Health, or Substance Abuse		
Mental/Behavioral Health Outpatient Services	$15 copay	25% coinsurance
Mental/Behavioral Health Inpatient Services *Must be pre-certified.*	$15 copay	25% coinsurance
Substance Use Disorder Outpatient Services	$15 copay	25% coinsurance
Substance Use Disorder Inpatient Services *Must be pre-certified.*	$15 copay	25% coinsurance
Testing		
Diagnostic Test (x-ray, blood work)	0% coinsurance	25% coinsurance
Imaging (CT/PET scans, MRIs)	0% coinsurance	25% coinsurance
Pregnancy		
Prenatal and Postnatal Care	$15 copay	25% coinsurance
Delivery and all Inpatient Services	$15 copay	25% coinsurance

Recovery and Other Special Health Needs

Home Health Care *Must be approved by the Plan office*.	$15 copay	25% coinsurance
Rehabilitation Services	$15 copay	25% coinsurance
Habilitation Services	$15 copay	25% coinsurance
Skilled Nursing Care *Must be approved by the Plan office.*	$15 copay	25% coinsurance
Durable Medical Equipment *Must be approved by the Plan office.*	$15 copay	25% coinsurance
Hospice Services *Limited to 90 days (aggregate).*	0% coinsurance	Not Covered

PRESCRIPTION DRUG PROGRAM

The information below indicates the participant's copay for the prescriptions indicated. Copayments listed are for covered prescription drugs obtained through Participating Pharmacies in the Prescription Drug Program.

Drug Type	**Retail***	**Mail****
Generic	20%	10%
Preferred Brand	20%	10%
Non-Preferred Brand	20%	10%

** Up to a 30-day supply.*
*** Up to a 90-day supply – medications prescribed for long term use (maintenance medication)*

Medication available over-the-counter including non-sedating antihistamines and proton pump inhibitors are not covered unless required under the Affordable Care Act. If the ***covered person*** purchases a brand name drug for which there is a generic bio-equivalent, the ***covered person*** will be required to pay the difference between the cost of the ***generic*** drug and the brand name requested, plus the usual ***generic co-insurance.***

VISION BENEFITS

Examination, Lenses, and Frames
Benefits are the same for Participating and Non-Participating Providers.

	Eye Exam	**Glasses**
Maximum benefit per person per calendar year	$30/one exam per year	$270/one pair of glasses per year

DENTAL BENEFITS

Dental benefits are provided through Administrative Services Only, Inc. (ASO) utilizing the MetroDENT Premier Dental Network.

DEATH, ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFIT

Amount of Benefit: $15,000

The Plan provides for payment of benefits to a designated Beneficiary upon the death of an Eligible Employee who dies while covered under this Plan, The Plan also provides accidental death, dismemberment, and loss of sight benefits.

UTILIZATION REVIEW

Utilization review is the process of evaluating if services, supplies, or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care. ***Utilization review*** can eliminate unnecessary services, ***hospitalizations,*** and shorten ***confinements*** while improving quality of care and reducing costs to the ***covered person*** and the ***Plan.***

Certification of ***medical necessity*** and appropriateness by the ***Utilization Review Organization*** does not establish eligibility under the ***Plan*** nor guarantee benefits.

The ***Plan*** requires pre-certification of certain services, supplies, or treatment, as specified below. Under this ***Plan's*** claim filing procedures, the pre-certification call is considered to be filing a ***pre-service claim*** for benefits. Please see *Claim Filing Procedures* for details regarding a ***covered person's*** rights regarding ***pre-service claim*** determinations and appeals.

PRE-CERTIFICATION

Hospital

All ***hospital*** admissions are to be certified in advance of the proposed ***confinement*** (pre-certification) by the ***Utilization Review Organization,*** except for ***emergencies***. **The *covered person* or their representative should call the *Utilization Review Organization* at least twenty-four (24) hours prior to admission.**

Covered persons should contact the Utilization Review Organization by calling MagnaCare at 1-888-362-4624.

***Emergency hospital* admissions are to be reported by the covered person or their representative to the *Utilization Review Organization* within seventy-two (72) hours following admission.**

*Group health plans 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 forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, Plans may not, under Federal law require that a provider obtain authorization from the **Plan** for prescribing a length of stay not in excess of the above periods.*

However, ***hospital*** maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be precertified.

Benefits payable for *hospital confinement* shall be reduced by one hundred dollars ($100) if pre-certification is not obtained.

After admission to the ***hospital,*** the ***Utilization Review Organization*** will continue to evaluate the ***covered person's*** progress through ***concurrent review*** to monitor the length of ***confinement*** and ***medical necessity*** of treatment. If the ***Utilization Review Organization*** disagrees with the length of ***confinement*** recommended by the ***physician,*** the ***covered person*** and the ***physician*** will be advised. If the ***Utilization Review Organization*** determines that continued ***confinement*** is no longer necessary, additional days will not be certified. **Benefits payable for days not certified as *medically necessary* by the *Utilization Review Organization* shall be denied.**

However, in the event that a ***retrospective review***, (a review completed after the event), determines that the hospitalization or surgery did not exceed the amount that would have been approved had the pre-certification been

completed, there will be no penalty assessed and the amount of any deductible and/or ***coinsurance*** will count towards the satisfaction of the ***covered person's*** maximum out-of-pocket expense.

PRE-CERTIFICATION APPEAL PROCESS

In the event certification of ***medical necessity*** is denied by the ***Utilization Review Organization,*** the ***covered person*** may appeal the decision. See *Claim Filing Procedures* for more information concerning the appeal process.

CASE MANAGEMENT/ALTERNATE TREATMENT

In cases where the ***covered person's*** condition is expected to be or is of a serious nature, the Trustees may arrange for review and/or case management services from a professional qualified to perform such services. The Trustees shall have the right to alter or waive the normal provisions of this ***Plan*** when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care. The use of case management or alternate treatment is a voluntary program to the ***covered person;*** however, the ***Plan*** will generally provide a greater benefit to the ***covered person*** by participating in the program.

Alternative care will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person.***

PREFERRED PROVIDER OR NON-PREFERRED PROVIDER

Covered persons have the choice of using either a ***preferred provider*** or a ***non-preferred provider.***

PREFERRED PROVIDERS

A ***preferred provider*** is a ***physician, hospital,*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons.*** This is known as the ***negotiated rate.*** The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate.*** Because the ***covered person*** and the ***Plan*** save money when services, supplies, or treatment are obtained from providers participating in the ***Preferred Provider Organization,*** benefits are usually greater than those available when using the services of a ***non-preferred provider. Covered persons*** should contact the ***Preferred Provider Organization*** for a current listing of ***preferred providers.***

NON-PREFERRED PROVIDERS

A ***non-preferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization.*** This ***Plan*** will allow only the ***customary and reasonable amount*** as a ***covered expense.*** The ***Plan*** will pay its percentage of the ***customary and reasonable amount*** for the ***non-preferred provider*** services, supplies, and treatment. The ***covered person*** is responsible for the remaining balance. This results in greater out-of-pocket expenses to the ***covered person.***

REFERRALS

Referrals to a ***non-preferred provider*** are covered as ***non-preferred provider*** services, supplies, and treatments. It is the responsibility of the ***covered person*** to assure services to be rendered are performed by ***preferred providers*** in order to receive the ***preferred provider*** level of benefits.

EXCEPTIONS

The following listing of exceptions represents services, supplies, or treatments rendered by a ***non-preferred provider*** where ***covered expenses*** shall be payable at the ***preferred provider*** level of benefits:

1. ***Non-preferred*** emergency room physician if the treatment is rendered in a preferred facility.

2. ***Non-preferred*** anesthesiologist if the operating ***facility*** is a ***preferred provider.***

3. Radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by a ***non-preferred provider*** when the ***facility*** rendering such services is a ***preferred provider.***

MEDICAL EXPENSE BENEFIT

This section describes the ***covered expenses*** of the ***Plan.*** All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***co-pay, coinsurance,*** and ***maximum benefit*** provisions as shown in the *Schedule of Benefits*, unless otherwise indicated. Any expenses ***incurred*** by the ***covered person*** for services, supplies, or treatment provided will not be considered ***covered expenses*** by this ***Plan*** if they are greater than the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable**.** The ***covered expenses*** for services, supplies, or treatment provided must be recommended by a ***physician*** or ***professional provider*** and be ***medically necessary*** care and treatment for the ***illness*** or ***injury*** suffered by the ***covered person.*** Specified preventive care expenses will be covered by this ***Plan.***

DEDUCTIBLES

Individual Deductible

The individual deductible is the dollar amount of ***covered expense*** which each ***covered person*** must have ***incurred*** during each calendar year before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits.*

COINSURANCE

The ***Plan*** pays a specified percentage of ***covered expenses*** at the ***customary and reasonable amount*** for ***non-preferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers***. That percentage is specified in the *Schedule of Benefits*. The ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the ***negotiated rate*** for ***preferred providers.*** For ***non-preferred providers***, the ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the billed amount. The ***covered person's*** portion of the ***coinsurance*** represents the out-of-pocket expense limit.

CALENDAR YEAR OUT-OF-POCKET EXPENSE LIMIT

After the ***covered person*** has incurred an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses*** for the services of ***preferred providers*** (after satisfaction of any applicable ***co-pays***), the ***Plan*** will begin to pay one hundred percent (100%) for ***covered expenses*** for the services of ***preferred providers*** for the remainder of the calendar year.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit:

1. Expenses for services, supplies, and treatments not covered by this ***Plan,*** to include charges in excess of the ***customary and reasonable amount,*** as applicable**.**

2. Deductible(s).

3. Expense ***incurred*** as a result of failure to obtain pre-certification.

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits; refer to *Utilization Review.*

Covered expenses shall include:

1. ***Room and board*** for treatment in a ***hospital,*** including ***intensive care units,*** cardiac care units, and similar necessary accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate*** rate. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***customary and reasonable amount*** or ***negotiated rate,*** as applicable**.**

2. Miscellaneous ***hospital*** services, supplies, and treatments including, but not limited to:
   a. Admission fees and other fees assessed by the ***hospital*** for rendering ***medically necessary*** services, supplies, and treatments;
   b. Use of operating, treatment, or delivery rooms;
   c. Anesthesia, anesthesia supplies, and its administration by an Employee of the ***hospital;***
   d. Medical and surgical dressings and supplies, casts, and splints;
   e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing, and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   f. Drugs and medicines (except drugs not used or consumed in the ***hospital);***
   g. X-ray and diagnostic laboratory procedures and services;
   h. Oxygen and other gas therapy and the administration thereof;
   i. Therapy services.

3. Services, supplies, and treatments described above furnished by an ***ambulatory surgical facility.***

FACILITY PROVIDERS

Services of ***facility*** providers if such services would have been covered if performed in a ***hospital*** or ***ambulatory surgical facility.***

AMBULANCE SERVICES

Ambulance services must be by a licensed air or ground ambulance.

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the ***covered person*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the ***covered person*** between ***hospitals*** for required treatment when such treatment is certified by the attending ***physician*** as ***medically necessary.*** Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.

PHYSICIAN SERVICES

Covered expenses shall include:

1. Medical treatment, services, and supplies including, but not limited to: office visits and ***inpatient*** visits.

2. Surgical treatment. Separate payment will not be made for ***inpatient*** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

3. Surgical assistance provided by a ***physician*** if it is determined that the condition of the ***covered person*** or the type of surgical procedure requires such assistance.

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.

5. Consultations requested by the attending ***physician*** during a ***hospital confinement.*** Consultations do not include staff consultations which are required by a ***hospital's*** rules and regulations.

6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests, and allergy injections.

SECOND SURGICAL OPINION

Benefits for a second surgical opinion will be payable according to the *Schedule of Benefits* if an ***elective surgical procedure*** (non-emergency surgery) is recommended by the ***physician***. The ***physician*** rendering the second opinion regarding the ***medical necessity*** of such surgery must be a board-certified specialist in the treatment of the ***covered person's illness*** or ***injury*** and must not be affiliated in any way with the ***physician*** who will be performing the actual surgery.

In the event of conflicting opinions, a request for a third opinion may be obtained. The ***Plan*** will consider payment for a third opinion the same as a second surgical opinion.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging, and x-ray.

TRANSPLANT

Services, supplies, and treatments in connection with human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** subject to the following conditions:

1. When the recipient is covered under this ***Plan,*** the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.

2. When the donor is covered under this ***Plan,*** the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant. If the recipient is also a ***covered person, covered expenses incurred*** by each person will be considered separately for each person.

3. Expenses ***incurred*** by the donor who is not ordinarily covered under this ***Plan*** according to *Eligibility* requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government Plan or individual policy of health coverage, and provided the recipient is covered under this ***Plan.*** The donor's expense shall be applied to the recipient's ***maximum benefit.*** In no event will benefits be payable in excess of the ***maximum benefit*** still available to the recipient.

4. Surgical, storage, and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under this ***Plan.***

   If a ***covered person's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

Benefits for organ or tissue transplants are subject to the ***maximum benefit*** shown on the *Schedule of Benefits.*

WILMS TUMOR

Covered expenses shall include charges for treatment of Wilms Tumor, including charges for autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful.

PREGNANCY

Covered expenses for ***pregnancy*** or ***complications of pregnancy*** shall be provided for a covered female ***Employee*** and the covered female spouse or dependent of a covered ***Employee***.

In the event of early discharge from a ***hospital*** or ***birthing center*** following delivery, the ***Plan*** will cover two (2) Registered Nurse home visits.

The ***Plan*** does not cover services, supplies, and treatments for elective abortions or complications from an abortion, except in cases of rape, incest or if necessary, to preserve the life or health of the pregnant woman.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of his license and the ***birthing center*** meets all legal requirements.

Services of a midwife acting within the scope of his license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

STERILIZATION

Covered expenses shall include elective sterilization procedures for the covered ***Employee*** or covered spouse. Reversal of sterilization is not a ***covered expense.***

INFERTILITY

Covered expenses for infertility testing are limited to the actual testing for a diagnosis of infertility. Any outside intervention procedures (e.g. artificial insemination) will not be a ***covered expense***.

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care while the mother is confined for delivery for a period not to exceed forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours following a Cesarean Section. However, if a different length of stay is provided in accordance with the guidelines established by the:

1. American College of Obstetricians and Gynecologists, and

2. American Academy of Pediatrics;

then, benefits will be paid in accordance with such guidelines.

WELL CHILD CARE/AFFORDABLE CARE ACT PREVENTIVE SERVICES

*The following are **covered expenses*** that are provided without your having to pay a copayment or co-insurance or meet your deductible. This applies only when these services are delivered by a network provider. This list is subject to change from time to time as the Affordable Care Act (ACA) provisions are updated.

Covered Preventive Services for Children

1. **Alcohol and Drug Use** assessments for adolescents
2. **Autism** screening for children at 18 and 24 months
3. **Behavioral** assessments for children of all ages
   Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
4. **Blood Pressure** screening for children
   Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
5. **Cervical Dysplasia** screening for sexually active females
6. **Congenital Hypothyroidism** screening for newborns
7. **Depression** screening for adolescents
8. **Developmental** screening for children under age 3, and surveillance throughout childhood
9. **Dyslipidemia** screening for children at higher risk of lipid disorders
   Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
10. **Fluoride Chemoprevention** supplements for children without fluoride in their water source
11. **Gonorrhea** preventive medication for the eyes of all newborns
12. **Hearing** screening for all newborns
13. **Height, Weight, and Body Mass Index** measurements for children
    Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
14. **Hematocrit or Hemoglobin** screening for children
15. **Hemoglobinopathies** or sickle cell screening for newborns
16. **HIV** screening for adolescents at higher risk
17. **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Haemophilus Influenzae Type B
    - Hepatitis A

- Hepatitis B
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

18. **Iron** supplements for children ages 6 to 12 months at risk for anemia
19. **Lead** screening for children at risk of exposure
20. **Medical History** for all children throughout development
    Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
21. **Obesity** screening and counseling
22. **Oral Health** risk assessment for young children
    Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
23. **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
24. **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk
25. **Tuberculin** testing for children at higher risk of tuberculosis
    Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
26. **Vision** screening for all children

COVERED PREVENTIVE SERVICES FOR ADULTS

*The following are **covered expenses*** that are provided without your having to pay a copayment or co-insurance or meet your deductible. This applies only when these services are delivered by a network provider. This list is subject to change from time to time as the Affordable Care Act (ACA) provisions are updated.

1. **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
2. **Alcohol Misuse** screening and counseling
3. **Aspirin** use for men and women of certain ages
4. **Blood Pressure** screening for all adults
5. **Cholesterol** screening for adults of certain ages or at higher risk
6. **Colorectal Cancer** screening for adults over 50
7. **Depression** screening for adults
8. **Type 2 Diabetes** screening for adults with high blood pressure
9. **Diet** counseling for adults at higher risk for chronic disease
10. **HIV** screening for all adults at higher risk
11. **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (Flu Shot)

- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella

12. **Obesity** screening and counseling for all adults
13. **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
14. **Tobacco Use** screening for all adults and cessation interventions for tobacco users
15. **Syphilis** screening for all adults at higher risk

COVERED PREVENTIVE SERVICES FOR WOMEN

*The following are **covered expenses*** that are provided without your having to pay a copayment or co-insurance or meet your deductible. This applies only when these services are delivered by a network provider. This list is subject to change from time to time as the Affordable Care Act (ACA) provisions are updated.

1. **Anemia** screening on a routine basis for pregnant women
2. **Bacteriuria** urinary tract or other infection screening for pregnant women
3. **BRCA** counseling about genetic testing for women at higher risk
4. **Breast Cancer Mammography** screenings every one to two years for women over 40
5. **Breast Cancer Chemoprevention** counseling for women at higher risk
6. **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
7. **Cervical Cancer** screening for sexually active women
8. **Chlamydia Infection** screening for younger women and other women at higher risk
9. **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drug
10. **Domestic and interpersonal violence** screening and counseling for all women
11. **Folic Acid** supplements for women who may become pregnant
12. **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
13. **Gonorrhea** screening for all women at higher risk
14. **Hepatitis B** screening for pregnant women at their first prenatal visit
15. **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women
16. **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
17. **Osteoporosis** screening for women over age 60 depending on risk factors
18. **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
19. **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. **Sexually Transmitted Infections (STI)** counseling for sexually active women
21. **Syphilis** screening for all pregnant women or other women at increased risk
22. **Well-woman visits** to obtain recommended preventive services

THERAPY SERVICES

Therapy services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury,*** for congenital anomaly, or for prevention of continued deterioration of function. ***Covered expenses*** shall include:

1. Services of a ***professional provider*** for speech therapy that supplements speech therapy services required to be provided by local school boards under applicable law, subject to the ***maximum benefit*** specified on the *Schedule of Benefits.*

2. Radiation therapy and chemotherapy.

3. Dialysis therapy or treatment.

4. Home infusion therapy.

5. Services of a ***professional provider*** for occupational or respiratory therapy.

EXTENDED CARE FACILITY

Extended care facility services, supplies, and treatments shall be a ***covered expense*** provided:

1. The ***covered person*** was first confined in a ***hospital*** for at least three (3) consecutive days;

2. The attending ***physician*** recommends extended care ***confinement*** for a convalescence from a condition which caused that ***hospital confinement,*** or a related condition;

3. The extended care ***confinement*** begins within fourteen (14) days after discharge from that ***hospital confinement,*** or within fourteen (14) days after a related extended care ***confinement;*** and

4. The ***covered person*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered person*** must have twenty-four (24) hours-per-day nursing care.

Covered expenses shall include:

1. ***Room and board*** (including regular daily services, supplies, and treatments furnished by the ***extended care facility)*** limited to the ***facility's*** average ***semiprivate*** room rate; and

2. Other services, supplies, and treatment ordered by a ***physician*** and furnished by the ***extended care facility*** for ***inpatient*** medical care.

Extended care facility benefits are limited as shown in the *Schedule of Benefits*.

DURABLE MEDICAL EQUIPMENT

Rental or purchase, whichever is less costly, of necessary ***durable medical equipment*** which is prescribed by a ***physician*** and required for therapeutic use by the ***covered person*** shall be a ***covered expense.*** Equipment ordered prior to the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage.

Repair or replacement of purchased ***durable medical equipment*** which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense.***

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the ***covered person's*** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the ***covered person's*** medical needs.

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a ***covered expense***. A prosthesis ordered prior to the ***covered person's effective date*** of coverage is not covered, even if delivered after the ***effective date*** of coverage.

Repair or replacement of a prosthesis which is ***medically necessary*** due to normal use or physiological change in the patient's condition will be considered a ***covered expense.***

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting, and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered.

Replacement will be covered only after five (5) years from the date of original placement, unless growth and development of a child necessitates earlier replacement.

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury.*** Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

Covered expenses shall also include charges for the surgical extraction of teeth and the treatment of tumors or cysts.

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; crutches; electronic pacemakers; oxygen and the administration thereof; soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye; blood and blood plasma that is not donated or replaced;

surgical dressings; and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

COSMETIC SURGERY

Cosmetic surgery shall be a ***covered expense*** provided:

1. A ***covered person*** receives an ***injury*** as a result of an accident and, as a result requires surgery. ***Cosmetic surgery*** and treatment must be for the purpose of restoring the ***covered person*** to his normal function immediately prior to the accident.

2. It is required to correct a congenital anomaly, for example, a birth defect, for a child.

3. It is incidental to or follows surgery resulting from trauma, infection, or other disease of the involved part.

4. It is for reconstructive breast reduction on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.

MASTECTOMY

Covered expenses shall include the following:

1. ***Medically necessary*** mastectomy, including complications from a mastectomy, including lymphedemas.

2. Reconstructive breast surgery necessary because of a mastectomy.

3. Reconstructive breast surgery on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.

4. External breast prosthesis and permanent internal breast prosthesis.

ACUPUNCTURE

Acupuncture to induce surgical anesthesia or for therapeutic purposes shall be a ***covered expense.***

PODIATRY SERVICES

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures of dislocations of bones of the foot.

SURCHARGES

Any excise tax, sales tax, surcharge, (by whatever name called) imposed by a governmental entity for services, supplies and/or treatments rendered by a ***professional provider, physician, hospital, facility,*** or any other health care provider shall be a ***covered expense*** under the terms of the ***Plan.***

REHABILITATION PROGRAMS

Covered expenses shall include charges for qualified cardiac/pulmonary rehabilitation programs.

MEDICAL EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under this ***Plan*** for medical expenses for the following:

1. Charges for services, supplies, or treatment for the reversal of sterilization procedures.

2. Charges for or in connection with: treatment of disease of the teeth; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

3. Charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses; or dispensing optician's services.

4. Expenses for a ***cosmetic surgery*** or procedure and all related services, except as specifically stated in *Medical Expense Benefit* and *Cosmetic Surgery.*

5. Charges for ***custodial care,*** domiciliary care, or rest cures.

6. Charges for recreational or leisure therapy.

7. Charges for services, supplies, or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician,*** such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, or exercise equipment.

8. Charges for travel or accommodations, whether or not recommended by a ***physician,*** except as specifically provided herein.

9. Charges for services, supplies, and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches.

10. Charges for expenses related to hypnosis.

11. Charges for prescription drugs that are covered under the *Prescription Drug Program* or for the Prescription Drug ***co-pay*** applicable thereto.

12. Charges for any services, supplies, or treatment not specifically provided herein.

13. Charges for professional services billed by a ***physician*** or Registered Nurse, Licensed Practical Nurse, or Licensed Vocational Nurse who is an Employee of a ***hospital*** or any other ***facility*** and who is paid by the ***hospital*** or other ***facility*** for the service provided.

14. Charges for environmental change including ***hospitalization*** or ***physician*** charges connected with prescribing an environmental change.

15. Charges for ***room and board*** in a ***facility*** for days on which the ***covered person*** is permitted to leave (a weekend pass, for example.)

16. Charges for services, supplies, or treatment for gender dysphoria, or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical, or psychiatric treatment.

17. Charges for treatment or surgery for sexual dysfunction or inadequacy, unless related to organic ***illness.***

18. Charges for ***hospital*** admission on Friday, Saturday, or Sunday unless the admission is an ***emergency*** situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, ***hospital*** expenses will be payable commencing on the date of actual surgery.

19. Charges for ***inpatient room and board*** in connection with a ***hospital confinement*** primarily for diagnostic tests, unless it is determined by the ***Plan*** that ***inpatient*** care is ***medically necessary.***

20. Charges for services, supplies, or treatments which are primarily educational in nature; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

21. Charges for marital counseling.

22. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

23. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts.

24. Charges for services, supplies, or treatment primarily for weight reduction or treatment of obesity (with the exception of counseling services required under the Affordable Care Act), including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and ***hospital confinements*** for weight reduction programs.

25. Charges for chelation therapy, except as treatment of heavy metal poisoning.

26. Charges for sex therapy, diversional therapy, or recreational therapy.

27. Charges for procurement and storage of one's own blood, unless ***incurred*** within three (3) months prior to a scheduled surgery.

28. Charges for holistic medicines or providers or naturopathy.

29. Charges for or related to the following types of treatment:
    a. primal therapy;
    b. rolfing;
    c. psychodrama;
    d. megavitamin therapy;
    e. visual perceptual training.

30. Charges for structural changes to a house or vehicle.

31. Charges for a newborn child of a dependent child.

32. Charges for services, supplies, and treatments for elective abortions or complications from an abortion.

33. Charges for benefits, when it is determined that medical expenses have resulted from participation in inherently dangerous or ultra-hazardous activities, including but not limited to: base jumping, water skiing, bungee jumping, riding on all-terrain vehicle as a passenger or driver, motor cross, etc.

34. Physical Therapy expenses accept as specifically stated in the Schedule of Benefits (Grandfathered Employees).

35. Behavioral Health and Substance Abuse expenses accept as specifically stated in the Schedule of Benefits (Grandfathered Employees).

PRESCRIPTION DRUG PROGRAM

PHARMACY OPTION

Participating pharmacies have contracted with EnvisionRx to charge the ***Plan*** and ***covered persons*** reduced fees for covered prescription drugs.

CO-PAY

The ***co-pay*** is applied to each covered pharmacy drug charge and is shown on the S*chedule of Benefits*. The ***co-pay*** amount is not a ***covered expense*** under the *Medical Expense Benefit.* Any one prescription is limited to a thirty (30) day supply.

If a drug is purchased from a ***nonparticipating pharmacy*** or a ***participating pharmacy*** when the ***covered person's*** ID card is not used, the ***covered person*** must pay the entire cost of the prescription, including ***co-pay,*** and then submit the receipt to the ***Pharmacy Organization*** for reimbursement. If a ***nonparticipating pharmacy*** is used, the ***covered person*** will be responsible for the ***co-pay,*** plus the difference in cost between the ***participating pharmacy*** and ***nonparticipating pharmacy.***

If the ***covered person*** purchases a brand name drug when a ***generic drug*** can be dispensed, the ***covered person*** will be required to pay the difference between the ***generic drug*** and the brand name requested, plus the usual generic ***co-pay.***

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer ***covered persons*** significant savings on prescriptions.

If the ***covered person*** purchases a brand name drug when a ***generic drug*** can be dispensed, the ***covered person*** will be required to pay the difference between the ***generic drug*** and the brand name requested, plus the usual generic ***co-pay.***

CO-PAY

The ***co-pay*** is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits.* It is not a ***covered expense*** under the *Medical Expense Benefit.* Any one prescription is limited to a ninety (90) day supply.

COVERED PRESCRIPTION DRUGS

1. All drugs prescribed by a ***physician*** that require a prescription either by federal or state law, except drugs excluded by the ***Plan.***

2. All compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Insulin when prescribed by a ***physician*** and the following diabetic supplies: insulin syringes and needles; urine testing strips for glucose; lancets and lancet devices; alcohol swabs; ketone testing strips; blood testing strips for glucose; and ketose tablets.

4. Tretinoin, all dosage forms (e.g. Retin-A), for treatment of acne only, for ***covered persons*** under age twenty-six (26).

LIMITS TO THIS BENEFIT

This benefit applies only when a ***covered person incurs*** a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a ***physician.***

2. Refills up to one year from the date of order by a ***physician.***

EXPENSES NOT COVERED

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin or drugs included under the Affordable Care Act.

2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.

3. Immunization agents or biological sera; blood or blood plasma.

4. A drug or medicine labeled: "Caution - limited by federal law to investigational use."

5. Experimental drugs and medicines, even though a charge is made to the ***covered person.***

6. Any charge for the administration of a covered prescription drug.

7. Any drug or medicine that is consumed or administered at the place where it is dispensed.

8. A drug or medicine that is to be taken by the ***covered person***, in whole or in part, while ***hospital confined.*** This includes being confined in any institution that has a facility for dispensing drugs.

9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.

10. A charge for hypodermic syringes and/or needles (other than insulin), insulin pens, and cartridges.

11. A charge for infertility medication.

12. A charge for any drug used for cosmetic purposes, including, but not limited to:
    a. Drugs whose sole purpose is to stimulate or promote hair growth (e.g. Minoxidil); and
    b. Tretinoin, all dosage forms (e.g. Retin-A) for ***covered persons*** age twenty-six and older.

13. A charge for growth hormones and all analogs.

14. A charge for appetite suppressants or drugs used for the purpose of weight loss, unless ***medically necessary*** for the treatment of Attention Deficit Disorder (ADD) and Narcolepsy.

15. All vitamins.

16. A charge for erectile dysfunction medication.

17. Smoking deterrents.

DENTAL EXPENSE BENEFIT

HOW DENTAL COVERAGE WORKS

The dental benefits provided pay up to the amounts shown in the Schedule of Covered Dental Allowances subject to the Maximum Benefit Limit. Covered dental expenses included under the Plan are the charges of a dentist which a Participant is required to pay for dental services listed in the Schedule of Covered Dental Allowances and received while coverage is in effect.

For each service, however, the covered dental expense will not be more than the amount set forth in the Schedule for the particular dental service. If the charges are less than the Schedule amount for the particular service, the amount included as a covered dental expense will equal the actual charges.

Dental benefits are self-insured by the Teamsters Local 966 Health Fund but are administered through Administrative Services Only, Inc. (ASO) utilizing the MetroDENT Premier Dental Network.

SCHEDULE OF COVERED DENTAL ALLOWANCES

Covered expenses include charges incurred for the performance of dental services provided for in the Schedule of Covered Dental Allowances when the dental service is performed by or under the direction of a duly licensed ***dentist***, is essential dental care, and begins and is completed while the individual is covered for benefits. The schedule below shows the maximum the ***Fund*** will pay for any particular dental service.

Diagnostic and Preventive	**Plan Allowance**
ORAL EXAMINATION Maximum of two per calendar year	$ 20.00
FULL MOUTH SERIES X-RAYS OR PANORAMIC FILM 10 to 14 periapical and bitewing films	$ 40.00
INTRAORAL FILM Periapical or bitewing, per film	$ 5.00
OCCLUSAL FILM	$ 10.00
CEPHALOMETRIC FILM	$ 40.00
POSTERIOR-ANTERIOR FILM	$ 20.00
LATERAL FILM	$ 20.00
TEMPOROMANDIBULAR FILM $40 x-ray maximum per calendar year	$ 20.00
PROPHYLAXIS, including scaling and polishing Adult Child maximum of two per calendar year	 $ 30.00 $ 28.00

FLUORIDE TREATMENT Excluding prophylaxis to age 19, one application per calendar year	$ 10.00
SEALANT Unrestored permanent posterior teeth only, to age 19 Lifetime maximum of $45 per quadrant	$ 15.00
SPACE MAINTAINER Fixed	$150.00

Basic Restorative

SILVER AMALGAM FILLINGS	
one surface	$ 45.00
two surfaces	$ 55.00
three surfaces	$ 60.00
four or more surfaces	$ 65.00
COMPOSITE RESIN	
one surface	$ 50.00
two surfaces	$ 60.00
three or more surfaces	$ 70.00
four or more and incisal angle	$ 80.00

Major Restorative

Pre-operative periapical x-ray required.
There is a 5-year frequency limitation on replacements.

CROWNS	
Plastic	$150.00
Porcelain jacket	$350.00
Plastic with metal	$375.00
Porcelain with metal	$425.00
Full or ¾ cast	$350.00
METALLIC INLAY	
One surface	$200.00
Two surfaces	$230.00
Three surfaces	$260.00
PORCELAIN INLAY	
One surface	$200.00
Two surfaces	$230.00
Three surfaces	$260.00
STAINLESS STEEL CROWN	
Primary tooth	$ 75.00
CAST POST & CORE	$125.00
PREFAB POST & CORE	$ 75.00

Endodontics
X-ray evidence of satisfactory completion required.

PULPOTOMY	$ 60.00
ROOT THERAPY	
Anterior	$225.00
Bicuspid	$275.00
Molar	$350.00
APICOECTOMY, per root	$130.00
APICOECTOMY, maximum per tooth	$260.00
RETROGRADE FILLING	$ 85.00
HEMISECTION/ROOT RESECTION	$150.00

Prosthodontics
Pre-operative x-rays are required when filing a claim for pretreatment review or payment on all prosthetics. X-rays of the full arch must be included for all bridgework. There is a five-year frequency limitation from date of installation on all prosthetics.

COMPLETE DENTURE	
Immediate or permanent	$600.00
PARTIAL DENTURE – Unilateral	$200.00
PARTIAL DENTURE – Bilateral	
Acrylic base with clasps and rests	$425.00
Cast metal base	$600.00
PRECISION ATTACHMENT	$125.00
BRIDGEPONTIC	
Full cast	$350.00
Plastic with metal	$375.00
Porcelain with metal	$425.00
ABUTMENT – INLAY 2 SURFACE	$230.00
ABUTMENT – INLAY 3 SURFACE	$260.00
CAST METAL RETAINER – ACID ETCH BRIDGE	$230.00
BRIDGE ABUTMENT	
Crown-plastic with metal	$375.00
Crown-porcelain fused to metal	$425.00
Crown-full cast	$350.00
DENTURE RELINE	
Chair	$ 75.00
Laboratory	$125.00

DENTURE REPAIRS	
Denture adjustment	$ 35.00
Repair cast framework	$100.00
Repair complete denture base	$ 90.00
Replace tooth in denture	$ 85.00
Replace broken facing	$100.00
Add tooth to existing partial denture	$ 85.00
RECEMENTATION	
Crown or inlay	$ 30.00
Bridge	$ 40.00

Periodontics

Although eight teeth constitute the anatomic complement of a quadrant, for purposes of settling claims for periodontal treatment, payment will be based on five teeth per quadrant. Accordingly, if at least five teeth are treated in a quadrant, payment will be based on the allowance for a full quadrant. If fewer than five teeth are treated, payment will be prorated on the basis of five teeth per quadrant. When more than one periodontal procedure is performed on the same day, claims for services will be combined and payment will be based on the most costly procedure.

ROOT SCALING, GINGIVAL CURETTAGE & BITE CORRECTION	
Including prophylaxis	
Per visit	$ 50.00
Periodontal maintenance	$ 50.00

Maximum allowance on any combination of the above services is $200 per calendar year.

PERIODONTAL SURGERY	
Confirmation by charting and/or x-rays required per quadrant of at least five teeth.	
Gingivectomy, gingivoplasty, and mucogingival surgery	
Per quadrant	$150.00
Osseous surgery, including gingivectomy per quadrant	$350.00
Osseous graft, single site	$ 90.00
Osseous graft, per quadrant	$300.00
Free soft tissue graft, per quadrant	$250.00
Pedicle soft tissue graft, per quadrant	$250.00

Oral Surgery

ROUTINE EXTRACTION	$ 50.00
SURGICAL EXTRACTION	
Must be demonstrated by pre-operative x-ray	
Erupted tooth	$750.00
Impaction-soft tissue	$115.00
Impaction-partial bony	$185.00
Impaction-complete bony	$225.00
REMOVAL OF RESIDUAL ROOTS	$ 90.00
SURGICAL EXPOSURE – UNERUPTED (for ortho)	$160.00
SURGICAL EXPOSURE – UNERUPTED (aid eruption)	$ 80.00
INCISION AND DRAINAGE – No other treatment that visit	$ 55.00

ALVEOLOPLASTY-per quadrant	$125.00
BIOPSY OF ORAL TISSUE	$ 80.00
REMOVAL OF CYST OR TUMOR	
Less than 1.25 cm	$ 75.00
Greater than 1.25 cm	$125.00
FRENULECTOMY	$ 95.00

Orthodontics – Discount Only

There is no orthodontic benefit payable by the Fund. However, Participating Orthodontists agree to limit their fees listed in the schedule. Members and their dependents using this program will be responsible to pay these fees directly to the Participating Orthodontist.

INITIAL FIXED APPLIANCES Maximum one per lifetime	$480.00
ACTIVE TREATMENT – per month Maximum of 24 months per lifetime	$ 60.00
POST-TREATMENT STABILIZATION DEVICE	$120.00
PASSIVE TREATMENT – per three months Maximum of nine months per lifetime	$ 60.00
MINOR TOOTH MOVEMENT	
Removable appliance-tooth guidance Maximum one per lifetime	$270.00
Harmful habit appliance Maximum one per lifetime	$270.00

Adjunctive Services

SPECIALIST CONSULTATION, including exam	$ 50.00
PALLIATIVE TREATMENT – No other treatment that visit	$ 30.00
GENERAL ANESTHESIA/IV SEDATION **first 30 minutes only**	$ 65.00

HOW TO FILE A DENTAL CLAIM

After dental work is performed, the Participant should have the ***dentist*** complete all items in the Dentist Information portion of the Claim Form and list the procedures, dates of services, and charges and sign in the space provided for ***dentist*** signature. The Participant should then complete all items in the Member Information portion. Be sure to include spouse and dependent information.

Completed claim forms, with x-rays and all attachments, should be sent to Administrative Services Only, Inc. (ASO), P.O. Box 9005, Dept. 95, Lynbrook, NY 11563-9005, (516) 396-5500, (800) 537-1238, note Payor ID: CX076. Dental claims must be filed within twelve months after the date of service. Claims filed later than twelve months from the date of service will not be reimbursed. If the Participant would like the payment made directly to the ***dentist***, the Participant may do so by signing the "Authorization to Assign Benefits" box on the claim form.

MAXIMUM BENEFIT

The maximum calendar year benefit payable on behalf of a ***covered person*** for covered dental expense is stated on the *Schedule of Benefits.* If the ***covered person's*** coverage under the ***Plan*** terminates and he subsequently returns to coverage under the ***Plan*** during the calendar year, the ***maximum benefit*** will be calculated on the sum of benefits paid by the ***Plan.***

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is ***incurred,*** except as follows:

1. for fixed bridgework and removable dentures, when the first impressions are taken and/or abutment teeth are prepared;

2. for a crown, on the first date of preparation of the tooth involved;

3. for root canal therapy, on the date the pulp chamber is opened.

EXTENSION OF BENEFITS

An expense incurred in connection with a dental service that is completed after the termination of a ***covered person's*** eligibility will be deemed to be incurred while that person was eligible if,

1. For crowns, fixed bridgework, and full or partial dentures, a pre-treatment authorization was issued and impressions were taken and/or teeth were prepared while the ***covered person*** was eligible and the device was installed or delivered within three months after the ***covered person's*** eligibility terminated.

2. For root canal therapy, the pulp chamber of the tooth was opened while the ***covered person*** was eligible and the treatment was completed within three months after the ***covered person's*** eligibility terminated.

PRE-TREATMENT REVIEW

Pre-treatment review is not mandatory but is highly recommended. The Participant may take advantage of this process so that the Participant and the ***dentist*** can be informed, in advance of treatment and before any expenses are incurred, what benefits are provided by the Dental Program. A claim form for pre-treatment review should be filed by the ***dentist*** if the course of treatment prescribed is expected to cost more than $500 in a 90-day period and/or includes any of the following services: crowns, bridges, dentures, orthodontics, inlays, or periodontal surgery. The ***dentist*** should complete the claim form describing the planned treatment and the intended charges before starting treatment. Mail the completed form, together with the necessary x-rays and other supporting documentation, to Administrative Services Only, Inc. (ASO) P.O. Box 9005, Dept. 95, Lynbrook, NY 11563-9005.

ASO will review the proposed treatment and apply the appropriate Plan provisions. The ***covered person*** and ***dentist*** will receive a report showing the amount the Plan will pay for each procedure. If there is a disallowance, it will be indicated, and an explanation will be provided. A pre-treatment authorization for a proposed course of treatment that was submitted by one ***dentist***, will remain valid if some or all of the work is done by another ***dentist***. The pre-treatment authorization will be honored for one year after issuance.

A pre-treatment authorization is not a promise of payment. Work must be completed while the ***covered person*** is still eligible for benefits under the ***Plan*** (except where there is an extension of benefits) provided no significant change occurred in the condition of the ***covered person's*** mouth after the pre-treatment estimate was issued. Payment will be made in accordance with ***Plan*** allowances and limitations in effect at the time services are provided.

ALTERNATE BENEFITS PROVISION

Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could produce a suitable result based on accepted dental standards. In these instances, although the ***covered person*** may elect to proceed with the original treatment plan, reimbursement allowances will be based on a less expensive alternate course of treatment. This should in no way be considered a reflection on the treating ***dentist's*** recommendations. By using the pre-treatment review and authorization procedures, the ***covered person*** and ***dentist*** can determine, in advance, what benefits are available for a given course of treatment. If the course of treatment has already begun, or has been completed without a pre-treatment authorization estimate, the benefits paid by the ***Plan*** may be based on the less expensive alternate treatment.

DENTAL EXCLUSIONS

In addition to the *Plan Exclusions*, no benefit will be provided under this ***Plan*** for dental expenses ***incurred*** by a ***covered person*** for the following:

1. Treatment that is solely for the purpose of cosmetic improvement.

2. Replacement of lost or stolen appliances.

3. Replacement of a bridge, crown, inlay, or denture within five years after the date it was originally installed.

4. Replacement of a bridge, crown, inlay, or denture which is or can be made usable according to common dental standards.

5. Multiple bridge abutments.

6. Procedures, appliances, or restorations (except full dentures) whose main purpose is to:
   a. change vertical dimension; or
   b. diagnose or treat conditions or dysfunctions of the temporomandibular joint; or
   c. stabilize periodontally involved teeth.

7. Dental services that do not meet common dental standards.

8. Services not included as Covered Dental Expense in the Dental Schedule.

9. Orthodontic services.

10. Services for which benefits are not payable according to the "Plan Exclusions" section.

METROPOLITAN RECLAMATION SERVICES GRANDFATHERED EMPLOYEES DENTAL BENEFIT

GENERAL BENEFITS PROVIDED

The dental benefits provided pay up to the amounts shown in the Schedule of Covered Dental Allowances subject to the Maximum Benefit Limit. Covered dental expenses included under the Plan are the charges of a dentist which a Participant is required to pay for dental services listed in the Schedule of Covered Dental Allowances and received while coverage is in effect.

For each service, however, the covered dental expense will not be more than the amount set forth in the Schedule for the particular dental service. If the charges are less than the Schedule amount for the particular service, the amount included as a covered dental expense will equal the actual charges.

Dental benefits are self-insured by the Teamsters Local 966 Health Fund but are administered through Administrative Services Only, Inc. (ASO) utilizing the MetroDENT Premier Dental Network.

ELIGIBILITY

Participants and eligible dependents, which include the lawful spouse and dependent children from birth until age 26, are eligible for dental benefits.

MAXIMUM BENEFIT LIMIT

For the period October 1, 2017 through December 31, 2017, the annual maximum is $750.00 per covered individual. On or after January 1, 2018, the dental benefit has a $3,000 annual per person maximum. This benefit is compiled on a calendar year basis and renews each January 1st.

ANNUAL DEDUCTIBLE

There is no annual deductible.

ALTERNATE BENEFITS PROVISION

When more than one dental service could provide suitable treatment based on common dental standards, reimbursement allowances will be based on a less expensive alternate course of treatment. By using the pre-treatment review and authorization procedures, you and your dentist can determine, in advance, what benefits are available for a given course of treatment. If the course of treatment has already begun or has been completed without a pretreatment authorization estimate, the benefits paid by the dental plan may be based on the less expensive treatment.

PRE-TREATMENT REVIEW

This process enables you to obtain knowledge, in advance of treatment, of the operation of your dental plan prior to undergoing treatment and incurring expenses. A Claim Form for Pre-Treatment Review should be filed by your dentist if the course of treatment is expected to cost more than $500 in a 90-day period and/or includes any of the following services: crowns, bridges, dentures, laminate veneers, or periodontal surgery. The dentist should complete the claim form describing the prescribed treatment and the expected charges before beginning treatment. You will then complete your portion of the form and mail it along with the necessary x-rays and other supporting documentation to Administrative Services Only, Inc (ASO), P.O. Box 9005, Dept. 77, Lynbrook, NY 11563-9005, (800) 537-1238.

Dental consultants will review the proposed treatment and apply the appropriate Plan provisions. Both you and your dentist will receive a report showing the amount the Plan will pay for each procedure. If there is a disallowance, it will be indicated, and an explanation provided. If you receive a pre-treatment authorization for a proposed course of treatment that was submitted by one dentist, that pre-authorization will remain valid if you elect to have some or all of the work performed by another dentist. The pre-authorization will be honored for one year after issuance. Pre-treatment authorization is not a promise of payment. Work must be completed while you are still covered by the Fund for benefits, except where there is an extension of benefits, and no significant change occurred in the condition of your mouth after the pre-estimate was issued. Payment will be made in accordance with Plan allowances and limitations in effect at the time services are provided.

COORDINATION OF BENEFITS PROVISION

If you or your family members are eligible to receive dental benefits under another group plan in addition to the Teamsters Local 966 Welfare Fund dental plan, benefits will be coordinated with the benefits from your other group plan so that up to 100% of the allowable expenses incurred will be paid jointly by the plans. The allowable expense for a procedure is defined as the average usual and customary charge for a specific geographic area. In order to obtain all of the benefits available, you and your family members should file claims under each plan. Participants should file with the primary plan first and then the secondary plan. Be certain to enclose a copy of the payment voucher from the primary plan when filing a claim with the secondary plan.

The birthday rule is applied for determining the primary carrier for payment of dental benefits for dependent children. The plan of the parent whose birthday, month, and day, falls first in the calendar year is the primary carrier. For example, if your birthday is July 9 and your spouse's birthday is October 27, your dental plan will be primary. Payment claims for dependent children should be submitted to the primary plan first, and then to the secondary plan, enclosing a copy of the payment voucher from the primary plan.

COVERED EXPENSES

Covered expenses include charges incurred from the performance of dental services provided for in the Schedule of Covered Dental Allowances when the dental service is performed by or under the direction of a duly licensed dentist, is essential dental care, and begins and is completed while the Participant is covered for benefits. A dental service is deemed to have begun when the actual performance of the service starts except that:

1. for fixed bridgework and removable dentures, it starts when the first impressions are taken and/or abutment teeth are prepared;

2. for a crown, it starts on the first date of preparation of the tooth involved;

3. for root canal therapy, it starts when the pulp chamber of the tooth is opened.

EXTENSION OF BENEFITS

An expense incurred in connection with a dental service that is completed after a Participant's benefits cease will be deemed to be incurred while that person was eligible if:

1. for crowns, fixed bridgework, and full or partial dentures, a pre-treatment authorization was issued and impressions were taken and/or teeth were prepared while that person was an eligible beneficiary and the device was installed or delivered within one month after the Participant's eligibility terminated;

2. for root canal therapy, the pulp chamber of the tooth was opened while the Participant was eligible for benefits and the treatment was completed within one month after the Participant's eligibility terminated.

There is no extension for any dental service not shown above.

GENERAL LIMITATIONS

No payment will be made for expenses incurred for the Participant or any one of the Participant's dependents:

1. for or in connection with services or supplies resulting from an accidental injury and which are deemed to be the responsibility of a third party;
2. for or in connection with a sickness or injury arising out of, or in the course of, any employment for wage or profit, which is covered under any workers compensation, occupational disease, or similar law;
3. for charges made by a hospital owned or run by the Federal, State, or Municipal agencies unless there is a legal obligation to pay such charges whether or not there is any insurance;
4. for charges which would not have been made if the person had no insurance, including services provided by a member of the patient's immediate family;
5. to the extent that they are more than reasonable and customary charges;
6. for charges for unnecessary care, treatment, or surgery;
7. to the extent that the Participant or any of the Participant's dependents is in any way paid for, or furnished by, any government agency, except Medicaid, or that the insured is not required to pay;
8. for a sickness or injury that is the result of war, declared or undeclared, or any act of war or aggression;
9. for an injury that is the result of participation in a felony, a riot, or an insurrection;
10. for or in connection with experimental procedures or treatment methods not accepted.

NETWORK DENTISTS

The MetroDENT Premier Dental Network dental plan is designed to substantially reduce or eliminate the non-reimbursed portion of your dental expense. Since usual and customary dental charges typically exceed dental plan reimbursements, Participants will realize a significant savings in the cost of dental care when using a participating MetroDENT Premier provider.

Participants will not incur any out-of-pocket expenses when a participating provider is used, except in the following instances:

1. where a specific co-payment is indicated;
2. for services that are listed in the Schedule of Covered Dental Allowances but for which the Plan will not pay, for example:
   a) where dental plan benefits exceed the calendar year maximum

b) where procedure frequency limitations have been met

3. for non-covered services.

SCHEDULE OF COVERED DENTAL ALLOWANCES

Covered expenses include charges incurred for the performance of dental services provided for in the Schedule of Covered Dental Allowances when the dental service is performed by or under the direction of a duly licensed ***dentist***, is essential dental care, and begins and is completed while the individual is covered for benefits. The schedule below shows the maximum the ***Fund*** will pay for any particular dental service, and the maximum a panel ***dentist*** will charge for that service.

Diagnostic	**Plan Allowance**
ORAL EXAM	$ 26.00
Two per calendar year.	
PERIAPICAL X-RAY-FIRST FILM	$ 9.00
PERIAPICAL X-RAY-EACH ADDITIONAL FILM	$ 5.00
BITEWING X-RAY-SINGLE FILM	$ 8.00
BITEWING X-RAYS-TWO FILMS	$ 13.00
BITEWING X-RAYS-FOUR FILMS	$ 18.00
OCCLUSAL FILM	$ 14.00
PANORAMIC	$ 48.00
Once every 2 years.	
FULL MOUTH SERIES	$ 75.00
Once every 2 years.	
CEPHALOMETRIC FILM	$ 50.00
Preventative	
PROPHYLAXIS-ADULT	$ 60.00
Two per calendar year.	
PROPHYLAXIS-CHILD UP TO AGE 14	$ 38.00
Once per 6 months.	
FLUORIDE EXCL PROPHY-TO AGE 14	$ 15.00
One application per 12 months.	
SEALANT-PER TOOTH-TO AGE 14	$ 27.00
One application per tooth on unrestored molar teeth.	
SPAC MAINTAINER-FIXED	$151.00
For dependent children under 19.	
Basic Restorative	
AMALGAM-1 SRF-primary or permanent tooth	$ 59.00
AMALGAM-2 SRF-primary or permanent tooth	$ 77.00
AMALGAM-3 SRF-primary or permanent tooth	$109.00
AMALGAM-4+ SRF-primary or permanent tooth	$109.00
RESIN-1 SRF-anterior	$ 82.00
RESIN-2 SRF-anterior	$114.00
RESIN-3 SRF-anterior	$156.00
RESIN-4 SRF & INCISAL ANGLE	$156.00
RESIN-1 SRF-posterior	$ 82.00
RESIN-2 SRF-posterior	$114.00
RESIN-3 SRF-posterior	$156.00
RESIN-4 OR MORE SRF-posterior	$156.00

Major Restorative Services

Replacement of the following services limited to once per 3 years*.

METALLIC INLAY-1 SRF*	$270.00
METALLIC INLAY-2 SRF*	$300.00
METALLIC INLAY-3 SRF*	$322.00
CROWN-RESIN WITH BASE METAL*	$752.00
CROWN-PORCELAIN WITH METAL*	$752.00
REPLACEMENT BRIDGE	$ 47.00
RECEMENT INLAY	$ 28.00
RECEMENT CROWN	$ 28.00
PREFAB SS CROWN-PRIMARY*	$101.00
PIN RETENTION-PER TOOTH	$ 36.00
CAST POST AND CORE*	$190.00
PREFAB POST AND CORE*	$166.00

V-Endodontics

X-ray evidence of satisfactory completion required.

PULP CAP	$ 20.00
VITAL PULPOTOMY	$ 70.00
ROOT CANAL THERAPY-anterior	$438.00
ROOT CANAL THERAPY-bicuspid	$504.00
ROOT CANAL THERAPY-molar	$629.00
APICOECTOMY-PER ROOT	$155.00
APICOECTOMY-ADDITIONAL ROOT	$ 38.00
RETROGRADDE FILLING	$ 62.00

Periodontics

Must be performed by a board-certified periodontist.
Maximum lifetime benefit, except for children under age 19 who are eligible as dependents - $1,500.

GINGIVECTOMY-PER QUADRANT	$343.00
OSSEOUS SURGERY-PER QUAD	$686.00
PEDICLE SOFT TISSUE GRAFT	$232.00
FREE SOFT TISSUE GRAFT	$284.00
OSSEOUS GRAFT-PER SITE	$296.00
OCCLUSAL ADJUSTMENT-LIMITED	$593.00
OCCLUSAL ADJUSTMENT-COMPLETE	$237.00
PERIODONTAL SCALING AND ROOT PLANING	$144.00
PERIODONTAL MAINTENANCE PROCEDURE	$ 75.00

Prosthodontic Repairs

DENTURE ADJUSTMENT-COMPLETE	$ 42.00
DENTURE ADJUSTMENT-PARTIAL	$ 42.00
REPAIR COMP DENT BASE	$ 69.00
REPLACE MISS/BRKN TTH-COM DENT	$ 55.00
REPAIR PART ACRYLIC SADDLE/BASE	$ 66.00
REPAIR CAST FRAMEWORK	$ 71.00
REPAIR OR REPLACE BROKEN CLASP	$ 59.00
REPLACE BROKEN TEETH-PER TOOTH	$ 55.00
ADD CLASP TO EXISTING PART DENT	$103.00
ADD TOOTH TO EXISTING PART DENT	$ 73.00
RELINE COMPLETE DENTURE-CHAIR	$ 76.00

RELINE PARTIAL DENTURE-CHAIR	$ 76.00
RELINE COMPLETE DENTURE-LAB	$185.00
RELINE PARTIAL DENTURE-LAB	$177.00

Prosthodontics

Replacement of a prosthetic once every 5 years.

COMPLETE DENTURE	$944.00
IMMEDIATE DENTURE	$944.00
PARTIAL DENTURE-ACRYLIC BASE	$931.00
PARTIAL DENTURE-CAST BASE	$931.00
UNILATERAL PARTIAL DENTURE	$399.00

Fixed Bridges

Replacement once in a 3 year period.

ABUTMENTS	$752.00
PONTIC-PORCELAIN TO METAL	$752.00
PONTIC-CAST METAL	$744.00

Oral Surgery

EXTRACTION	$ 84.00
SURGICAL EXTRACTION	$166.00
IMPACTION-SOFT TISSUE	$212.00
IMPACTION-PARTIAL BONEY	$300.00
IMPACTION-COMPLETE BONEY	$366.00
SURGICAL EXPOSURE-ORTHO	$226.00
SURGICAL EXPOSURE-AID ERUPTION	$226.00
ALVEOPLASTY	$ 78.00
INCISION & DRAINAGE	$ 48.00

No other treatment on that visit.

BIOPSY OF HARD TISSUE	$141.00
CYST REMOVAL <1.25CM	$259.00
CYST REMOVAL >1.25CM	$357.00
FRENULECTOMY	$111.00

Adjunctive Services

PALLIATIVE-EMERGENCY TREATMENT	$ 43.00

No other treatment rendered at same visit.

CONSULTATION BY A SPECIALIST	$ 36.00

Limit 2 in any 12 month period.

GENERAL ANESTHESIA **per 15 minutes**	$ 28.00
IV SEDATION **per 15 minutes**	$ 82.00

VISION EXPENSE BENEFIT

Vision benefits will be paid for covered vision expenses for ***covered persons*** as shown on the *Schedule of Benefits*. The benefits will apply when charges are ***incurred*** for vision care by a legally licensed ***physician*** or ***professional provider.***

COVERED VISION EXPENSE

The ***Plan*** provides coverage for services, supplies and treatment for the following:

1. Examinations and refractions performed by a licensed Optometrist or Ophthalmologist.
2. Lenses or contacts prescribed by such Optometrist or Ophthalmologist.
3. Frames purchased in conjunction with lenses newly prescribed.

VISION EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under this ***Plan*** for vision expenses ***incurred*** by a ***covered person*** for the following:

1. Services or supplies required as a condition of employment or by any governmental body.
2. Medical or surgical care of the eye.
3. Artificial eyes.
4. Any service performed, or supplies provided for special procedures such as orthoptics or any aids for sub-normal vision.

PEDIATRIC VISION

Pediatric vision benefits are also subject to the following frequencies and limitations:

Benefit	**Frequency once every**	**Coverage**
Eye Examination	12 months	Covered in full
Spectacle Lenses	12 months	Clear glass or plastic lenses in any single vision, bifocal, trifocal, or lenticular prescription. No coverage for tinting or coating or other special lens treatment.
Frame	24 months	Covered in full for standard or basic frame. No Fashion, Designer, or Premier frame coverage.
Contact Lenses		Not covered

BURIAL BENEFITS

The ***Fund*** has made arrangements with the Forest Park Green Cemetery in Morganville, New Jersey to reserve burial plots for the use of Local 966 members. This particular cemetery was selected because it is well maintained and is an association of separate cemeteries of different religious preferences.

Employees and their spouse (parent or child if unmarried) are entitled to free side-by-side gravesites. If a ***Fund*** gravesite is used for the ***Employee*** or the ***Employee's*** spouse, the adjoining gravesite is automatically reserved.

If the ***Employee*** has no spouse, one gravesite may be used by the ***Employee's*** mother, father, or child. Any unmarried dependent child who dies before age 23 (or at any age if physically handicapped or mentally handicapped and incapable of gainful employment) shall also receive a free adjoining gravesite. In such case, however, the ***Employee*** shall be required to pay for the perpetual care.

Contact the ***Third-Party Plan Administrator*** for full details about the cemetery's location and other provisions relating to this benefit.

METROPOLITAN RECLAMATION SERVICES GRANDFATHERED EMPLOYEES DEATH BENEFIT

DEATH BENEFIT

The Death benefit is payable in a lump sum payment, subject to the exclusions listed below, to the person or persons designated by you as Beneficiary. Payment will be made upon the submission of satisfactory proof of a death to the Plan.

Amount of Benefits: $15,000

ACCIDENTAL DEATH, DISMEMBERMENT, AND LOSS OF SIGHT BENEFITS

Accidental Death, Dismemberment and Loss of Sight benefits provide a lump sum payment of benefit to an Eligible Employee for accidental loss of limb or sight, and to an Eligible Employee's Beneficiary for the accidental loss of life. Loss of sight must be entire and irrevocable and must occur while covered by the Plan. Benefits are payable only for losses caused solely by and resulting within 90 days of and accidental bodily injury. The loss of life benefit is paid in addition to the Death benefit.

Designated Beneficiary

In order to designate your Beneficiary, you must submit a completed designation of Beneficiary form to the Fund Office. If you designate more than one Beneficiary, each surviving Beneficiary will receive an equal share of the Death Benefit unless you indicate otherwise on the form. You may change your Beneficiary at any time by submitting to the Fund Office a new Beneficiary Form, which has been properly completed by you. The appropriate form may be obtained by calling the Fund Office.

If your Beneficiary dies before you, or if you have not designated a Beneficiary, your Death Benefit will be paid to the surviving class of Beneficiary in the following order:

- Your surviving spouse
- Your surviving children, in equal shares
- Your surviving parents, in equal shares
- Your surviving brothers and sisters, in equal shares
- Your executors or administrators

If you Beneficiary is a minor, the benefit will be paid to his or her legally appointed guardian. Also, no benefit will be made to a beneficiary if that beneficiary caused the death of the participant.

EXCLUSIONS (Accidental Death and Dismemberment Only)

Loss caused or contributed by the following are not covered:

- Intentionally self-inflicted Injury;
- Suicide or attempted suicide, whether sane or insane;
- War or act of war, whether declared or not;
- Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
- Injury sustained while under the influence of any narcotics, unless administered by or consumed on the advice of a Physician;
- Any accident caused by your intoxication while operating a motor vehicle.

HOW TO CLAIM LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

In the event of the death of an Eligible Employee, the Fund office must be provided with an original death certificate. If the death is accidental, the accidental death benefit will automatically be applied.

To apply for the Dismemberment Benefit, you must supply the Fund office with the appropriate medical evidence.

PLAN EXCLUSIONS

The ***Plan*** will not provide benefits for any of the items listed in this section, regardless of ***medical necessity*** or recommendation of a ***physician*** or ***professional provider.***

1. Charges for services, supplies, or treatment from any ***hospital*** owned or operated by the United States government, or any agency thereof, or any government outside the United States, or charges for services, treatment, or supplies furnished by the United States government, or any agency thereof, or any government outside the United States, unless payment is legally required.

2. Charges for an ***injury*** sustained or ***illness*** contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, supplies, or treatment for ***illness*** or ***injury*** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience, or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Any condition for which benefits of any nature are recovered or are found to be recoverable, either by adjudication or settlement, under any Worker's Compensation law, employer's liability law, or occupational disease law, even though the ***covered person*** fails to claim rights to such benefits or fails to enroll or purchase such coverage.

5. Charges made for services, supplies, and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury,*** or which are not recommended and approved by the attending ***physician,*** except as specifically stated herein, or to the extent that the charges exceed the ***customary and reasonable amount*** or exceed the ***negotiated rate*** as applicable.

6. To the extent that payment under this ***Plan*** is prohibited by any law of the jurisdiction in which the ***covered person*** resides at the time the expense is ***incurred.***

7. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person's coverage, except as specifically provided herein.

8. Any services, supplies, or treatment for which the ***covered person*** is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

9. Charges for services, supplies, or treatment that is considered ***experimental/investigational.***

10. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***covered person*** or who resides in the same household as the ***covered person.***

11. Charges for services, supplies, or treatment rendered by physicians or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement,*** or service which is not recommended by or performed by an appropriate ***professional provider.***

12. Charges for ***illnesses*** or ***injuries*** suffered by a ***covered person*** due to the action or inaction of any party if the ***covered person*** fails to provide information as specified in *Subrogation.*

13. Claims not submitted within the ***Plan's*** filing limit deadlines as specified in *Claim Filing Procedures.*

14. Benefits which are payable under any one section of this ***Plan*** shall not be payable as a benefit under any other section of this ***Plan.*** For example, if a benefit is eligible under either the *Medical Expense Benefit*, *Dental Expense Benefit*, or the *Vision Expense Benefit* sections, and is paid under the *Medical Expense Benefit,* the remaining balance will **not** be paid under the Dental or *Vision Expense Benefits.*

15. Charges for e-mail or telephone consultations, completion of claim forms, or charges associated with missed appointments.

16. Charges in connection with any ***illness*** or ***injury*** arising out of or in the course of any employment intended for wage or profit, including self-employment.

17. Charges in connection with any ***illness*** or ***injury*** of the ***covered person*** resulting from or occurring during the ***covered person's*** commission or attempted commission of a criminal battery or felony, except that those resulting from a medical condition (such as mental illness) or incurred by the victim of an act of domestic violence shall be covered. Claims shall be denied if the ***Third-Party Plan Administrator*** has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery or felony was committed by the ***covered person***.

18. Charges ***incurred*** outside the United States if the ***covered person*** traveled to such a location for the sole purpose of obtaining services, supplies, or treatment.

ELIGIBILITY

This section identifies the ***Plan's*** requirements for a person to be eligible to enroll. Refer to *Enrollment* and *Effective Date of Coverage* for more information.

ACTIVE EMPLOYEE ELIGIBILITY

Collective Bargaining Employees

Employees of ***contributing Employers,*** whose employment is covered by the Collective Bargaining Agreement by and between Local Union 966 of the International Brotherhood of Teamsters and their Employer which requires contributions to be made to the Fund on their behalf, shall be eligible to enroll for coverage under this ***Plan.*** If permitted by the collective bargaining agreement covering their employment, Employees may opt out of coverage only if they provide proof of other creditable coverage, not including Medicare or Medicaid. Employees who opt out of coverage may opt in (enroll) for coverage 1) not less than 12 months after an opt-out in accordance with the dates specified in the participant's CBA or 2) during the month of November of each year, with coverage beginning on the following January 1, except as provided in the ***Special Enrollment*** section below. If a participant re-enrolls in coverage, the participant is eligible for benefits on the first of the month following the payment of contributions. In circumstances where a participant is employed and enrolled in benefits, the participant remains eligible for benefits if the employer pays contributions at any time in a month.

For any new employees, benefits commence on the first day of the month in which the third contribution is received. For example, a new Employee is hired on November 2, 2017 and on February 2, 2018, the new Employee's introductory period will be over. The Employer will make a payment for March 2018, April 2018, and May 2018 and coverage will commence May 1, 2018.

Non-Bargaining Employees

All full-time non-bargaining ***Employees*** of ***Employers*** who are regularly scheduled to work at least twenty (20) hours per work week shall be eligible to enroll for coverage under this ***Plan*** so long as the Employer enters into a Participation Agreement with the Fund**.** This does not include temporary or seasonal ***Employees.*** An ***Employer*** may contribute to the Health Fund on behalf of its full-time non-bargaining ***Employees.*** Contributions for non-bargaining ***Employees*** are permitted provided the Employer maintains its principal place of business within the geographic jurisdiction of Local Union 966 and the Employer has elected to contribute on behalf of all its full-time non-bargaining ***Employees*** beginning with the month in which they are first employed.

Contributions will not be accepted from an Employer on behalf of its non-bargaining ***Employees*** if that Employer has failed to make the required contributions for its bargaining ***Employees*** pursuant to a collective bargaining agreement with Local 966.

All full-time employees of Local Union 966, International Brotherhood of Teamsters shall be eligible to enroll for coverage under this Plan.

RETIREE ELIGIBILITY

No coverage is provided for ***Retired Employees*** or their dependents.

DEPENDENT(S) ELIGIBILITY

The following describes ***dependent*** eligibility requirements. The ***Trustees*** will require proof of ***dependent*** status.

1. The term "spouse" means the spouse of the ***Employee*** under a legally valid existing marriage, unless court ordered separation exists.

2. The term "child" means the ***Employee's*** biological child or legally adopted child, provided:
   a. The child has not reached the end of the month in which he or she attains age twenty-six (26).

3. An eligible child shall also include any other child of an ***Employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***, even if the child is not residing in the ***Employee's*** household. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage regardless of whether the ***Employee*** elect's coverage for himself. An application for enrollment must be submitted to the ***Trustees*** for coverage under this ***Plan***. The ***Trustees/ Third-Party Plan Administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the ***Trustees/ Third-Party Plan Administrator*** shall determine whether such order is a Qualified Medical Child Support Order (as defined in Section 609 of ERISA) or a National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

   The ***Trustees/ Third-Party Plan Administrator*** reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

4. Adopted children, who are less than 26 years of age at the time of adoption, shall be considered eligible from the date the child is ***placed for adoption.*** ***"Placed for adoption"*** means the date the ***Employee*** assumes legal obligation for the total or partial financial support of the child during the adoption process.

5. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the ***Employee*** for support due to a mental disorder/disability and/or physical disability, and who was covered under the ***Plan*** prior to reaching the maximum age limit or other loss of ***dependent's*** eligibility, will remain eligible for coverage under this ***Plan*** beyond the date coverage would otherwise be lost.

   Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the ***Trustees*** or ***claims processor,*** but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

   a. Cessation of the mental disorder/disability and/or physical disability;

   b. Failure to furnish any required proof of mental disorder/disability and/or physical disability or to submit to any required examination.

ENROLLMENT

APPLICATION FOR ENROLLMENT

An ***Employee*** must file a written application with the ***Third-Party Plan Administrator*** for coverage hereunder for himself and his eligible ***dependents*** within sixty (60) days of becoming eligible for coverage; and within sixty (60) days of marriage or the acquiring of children or birth of a child. The ***Employee*** shall have the responsibility of timely forwarding to the ***Third-Party Plan Administrator*** all applications for enrollment hereunder. If application for an eligible dependent is made in a timely manner, coverage will begin on the date the dependent became eligible for coverage; if application for an eligible dependent is not made in a timely manner, coverage will begin on the date of the application.

The ***Trustees*** must be notified of any change in eligibility of ***dependents,*** including the birth of a child that is to be covered and adding or deleting any other ***dependents.*** Forms are available from the ***Third-Party Plan Administrator*** for reporting changes in ***dependents'*** eligibility as required.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

An ***Employee*** or ***dependent*** who did not enroll for coverage under this ***Plan*** because he was covered under other group coverage or had health insurance coverage at the time, he was initially eligible for coverage under this ***Plan***, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits).

2. Cessation of Employer contributions toward the other coverage.

3. Legal separation or divorce.

4. Termination of other employment or reduction in number of hours of other employment.

5. Death of ***covered person.***

The end of any extended benefits period which has been provided due to any of the above will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage.)

The ***Employee*** or ***dependent*** must request the special enrollment and enroll no later than sixty (60) days from the date of loss of other coverage.

The effective date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the ***Third-Party Plan Administrator 's*** receipt of the completed enrollment form.

Special enrollment rights may arise if an individual declines coverage due to other coverage and then subsequently loses that coverage. The circumstances causing a loss of other coverage have been expanded:

Examples:

- Moving out of an HMO service area.
- A child losing *dependent* status.
- Losing coverage because of the exhaustion of another Plans' maximum lifetime benefit.

SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

An ***Employee*** who is not covered under the ***Plan***, but who acquires a new ***dependent*** may request a special enrollment period. For the purposes of this provision, the acquisition of a new ***dependent*** includes:

- marriage
- birth of a ***dependent*** child
- adoption or ***placement for adoption*** of a ***dependent*** child

The ***Employee*** must request the special enrollment within sixty (60) days of the acquisition of the ***dependent.***

The effective date of coverage as the result of a special enrollment shall be:

1. in the case of marriage, the first day of the first calendar month following the ***Third-Party Plan Administrator 's*** receipt of the completed enrollment form;

2. in the case of a ***dependent's*** birth, the date of such birth;

3. in the case of adoption or ***placement for adoption***, the date of such adoption or ***placement for adoption***.

If application for an eligible dependent is made in a timely manner, coverage will begin on the date the dependent became eligible for coverage; if application for an eligible dependent is not made in a timely manner, coverage will begin on the date of the application.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE(S) EFFECTIVE DATE

Eligible ***Employees,*** as described in *Eligibility,* are covered under the ***Plan*** on the date they become eligible.

1. *Collective Bargaining Employees*

   A collective bargaining Employee becomes eligible for benefits no more than ***90 days*** *after their employer's first obligation to make contributions to the Health Fund.*

   New Employees after January 1, 2015 will have Single Only Coverage for the first twelve (12) months. Following twelve-consecutive months of coverage, Family Coverage will be made available (unless the CBA only provides Single Only Coverage).

   Continuing Eligibility For Collective Bargaining Employees

   To continue eligibility after satisfying the initial requirements, the ***Employee*** must have continuing ***Employer*** contributions required to be made on his or her behalf to the Health Fund. An ***Employee's*** eligibility will terminate on the last day of the month for which an ***Employer*** contributes to the Health Fund on his or her behalf.

   If an ***Employer*** continuously fails to make required contributions and/or is excessively delinquent in making contributions on behalf of an ***Employee***, the ***Trustees*** have the right to terminate coverage.

   If a collective bargaining agreement requires an ***Employer*** to pay contributions on behalf of an ***Employee*** when he becomes unemployed, coverage will remain in effect for up to 12 consecutive months while those contributions are received.

   Reinstatement

   Should an ***Employee's*** eligibility terminate, it will be reinstated on the first day of the month following the ***Employee's*** return to covered employment provided the ***Employee*** returns within twenty-four (24) consecutive months after being last employed in covered employment. If the ***Employee*** does not return to covered employment within twenty-four (24) consecutive months, the ***Employee*** will be treated as a new ***Employee*** and will be subject to the requirements for initial eligibility outlined above.

2. *Non-Bargaining Employees*

   Eligible non-bargaining ***Employees,*** as described in *Eligibility,* are covered under the ***Plan*** *no more than* ***90 days*** *after their employer's first obligation to make contributions to the Health Fund.*

DEPENDENT(S) EFFECTIVE DATE

Eligible ***dependent(s),*** as described in *Eligibility,* will become covered under the ***Plan*** on the later of the dates listed below, provided the ***Employee*** has enrolled them in the ***Plan*** within sixty (60) days of meeting the ***Plan's*** eligibility requirements. If application for an eligible dependent is made in a timely manner, coverage will begin on the date the dependent became eligible for coverage; if application for an eligible dependent is not made in a timely manner, coverage will begin on the date of the application.

1. New Employees after January 1, 2015 will have Single Only Coverage for the first twelve (12) months of coverage by the Plan.

2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***Employee*** has applied for ***dependent*** coverage within sixty (60) days of the date acquired.

3. Newborn children will be considered a ***dependent*** under this ***Plan*** for sixty (60) days immediately following birth. For coverage under the ***Plan*** for the newborn beyond that date, the ***Employee*** must submit an application for enrollment within sixty (60) days of birth.

4. Coverage for a newly adopted child shall be effective on the date the child is ***placed for adoption.***

TERMINATION OF COVERAGE

Except as provided in the ***Plan's*** *Continuation of Coverage* (COBRA) or *Extension of Benefits* provision, coverage will terminate on the earliest of the following dates:

EMPLOYEE(S) TERMINATION DATE

Collective Bargaining Employees

1. The date the ***Plan*** terminates.
2. The date the ***Employee*** is no longer a member of an eligible class.
3. The date a change is made in this ***Plan*** to terminate coverage for an ***Employee's*** class.
4. The date contributions on the ***Employee's*** behalf cease.
5. The date the ***Employee*** fails to pay any required contribution when due.
6. The date the ***Employee*** enters into full-time active duty with the Armed Forces of any country.
7. The last day of the month for which an ***Employer*** is required to contribute to the Health Fund on an ***Employee's*** behalf.

Non-Bargaining Employees

1. The date the ***Plan*** terminates.
2. The date the ***Employee*** is no longer a member of an eligible class.
3. The date a change is made in this ***Plan*** to terminate coverage for an ***Employee's*** class.
4. The date contributions on the ***Employee's*** behalf cease.
5. The date the ***Employee*** fails to pay any required contribution when due.
6. The date the ***Employee*** enters into full-time active duty with the Armed Forces of any country.
7. The last day of the month for which an ***Employer*** is required to contribute to the Health Fund on an ***Employee's*** behalf.

DEPENDENT(S) TERMINATION DATE

1. The date the ***Employer*** terminates the ***Plan*** and offers no other group health Plan.
2. The date the ***Employee's*** coverage terminates. However, if the ***Employee*** remains eligible for the ***Plan,*** but elects to discontinue coverage, coverage may be extended for ***alternate recipients.***
3. The date such person ceases to meet the eligibility requirements of the ***Plan.***

4. The date the ***Employee*** ceases to make any required contributions on the ***dependent's*** behalf.

5. The date the ***dependent*** becomes a full-time**,** active member of the Armed Forces of any country.

6. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents.***

7. The date the ***dependent*** becomes eligible as an ***Employee.***

SURVIVOR'S BENEFITS

If an ***Employee*** dies while covered under this ***Plan,*** coverage will be continued for his surviving covered ***dependents,*** until the last day of the month of the ***Employee's*** death.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug, dental, and vision benefits as provided under the ***Plan.***

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a ***covered person*** to lose coverage under this ***Plan,*** even if such coverage is not lost immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage:*

1. Death of the ***Employee.***

2. The ***Employee's*** termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the ***Plan.***

3. Divorce or legal separation from the ***Employee.***

4. The ***Employee's*** entitlement to ***Medicare*** benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this ***Plan.***

5. A ***dependent*** child no longer meets the eligibility requirements of the ***Plan.***

6. The last day of leave under the Family Medical Leave Act of 1993.

7. The call-up of an ***Employee*** reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered ***Employee,*** or a child's loss of ***dependent*** status, the ***Employee*** or ***dependent*** must notify the ***Trustees/ Third-Party Plan Administrator,*** in writing, of that event within **sixty (60)** days of the event**.** The ***Employee*** or ***dependent*** must advise the date and nature of the qualifying event and the name, address, and Social Security number of the affected individual. **Failure to provide such notice to the *Trustees/ Third-Party Plan Administrator* will result in the person forfeiting their rights to continuation of coverage under this provision.**

2. Within fourteen (14) days of a qualifying event, or within fourteen (14) days of receiving notice of a qualifying event, the ***Employee*** or ***dependent*** will be notified of his rights to continuation of coverage, and what process is required to elect continuation of coverage.

3. After receiving notice, the ***Employee*** or ***dependent*** has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the ***Plan*** prior to the qualifying event, has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the ***Employee*** or ***dependent***

chooses to have continued coverage, he must advise the ***Trustees/ Third-Party Plan Administrator*** in writing of this choice. The ***Trustees/ Third-Party Plan Administrator*** must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the latter of the following:

a. The date coverage under the ***Plan*** would otherwise end; or
b. The date the person receives the notice from the ***Trustees/ Third-Party Plan Administrator*** of his or her rights to continuation of coverage.

4. Within forty-five (45) days after the date the person notifies the ***Trustees/ Third-Party Plan Administrator*** that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.

5. The ***Employee*** or ***dependent*** must make payments for the continued coverage.

COST OF COVERAGE

1. The ***Trustees*** require that ***covered persons*** pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. This must be remitted to the ***Trustees*** or the ***Trustee's*** designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

2. Cost of coverage will either be for an individual at the single employee rate or as a family at the family rate.

3. For purposes of determining monthly costs for continued coverage, a person originally covered as an individual or as a spouse will pay the rate applicable to an individual if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an individual.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the ***Plan.***

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent.*** The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with a covered ***Employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

SUBSEQUENT QUALIFYING EVENTS

Once covered under continuation coverage, it is possible for a second qualifying event to occur, including:

1. Death of an ***Employee.***

2. Divorce or legal separation from an ***Employee.***

3. ***Employee's*** entitlement to ***Medicare*** if it results in a loss of coverage under this ***Plan.***

4. The child's loss of ***dependent*** status.

If one of these subsequent qualifying events occurs, a ***dependent*** may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

Only a person covered prior to the original qualifying event or a child born to or ***placed for adoption*** with a covered ***Employee*** during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other ***dependent*** acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the ***Employee.***

2. Thirty-six (36) months from the date continuation began for ***dependents*** whose coverage ended because of the death of the ***Employee,*** divorce, or legal separation from the ***Employee,*** or the child's loss of ***dependent*** status.

3. The end of the period for which contributions are paid if the ***covered person*** fails to make a payment on the date specified by the ***Trustees.***

4. The date coverage under this ***Plan*** ends and the ***Employer*** offers no other group health benefit Plan.

5. The date the ***covered person*** first becomes entitled to ***Medicare*** after the date of election of COBRA continuation coverage.

6. The date the ***covered person*** first becomes covered under any other group health Plan after the date of election of COBRA continuation coverage.

EXTENSION FOR DISABLED INDIVIDUALS

A person who is ***totally disabled*** may extend continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the ***Trustees*** within the initial eighteen (18) month continuation coverage period and no later than sixty (60) days after the Social Security Administration's determination. The ***Trustees*** may charge 150% of the contribution during the additional eleven (11) months of continuation of coverage.

MILITARY MOBILIZATION

If an ***Employee*** or an ***Employee's dependent*** is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard, or the Public Health Service, the ***Employee*** or the ***Employee's dependent*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***Employee*** or ***Employee's dependent*** may not be required to pay more than the ***Employee's*** share, if any, applicable to that coverage. If the leave is more than thirty-one (31) days, then the ***Trustees*** may require the ***Employee*** or ***Employee's dependent*** to pay no more than 102% of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the ***Employee*** fails to return to employment within the time allowed.

The ***Employee*** or the ***Employee's dependent*** coverage will be reinstated without exclusions or a waiting period.

CLAIM FILING PROCEDURE

A claim for benefits is any request for a benefit which is provided by this ***Plan*** made by a ***covered person*** or the ***authorized representative*** of a ***covered person*** which complies with the ***Plan's*** procedures for making claims. Claims for health care benefits are one of two types: ***pre-service claims*** or ***post-service*** claims.

Pre-service claims are claims for services for which preapproval must be received before services are rendered in order for benefits to be payable under this ***Plan***, such as those services listed in the section *Utilization Review.* A ***pre-service claim*** is considered to be filed whenever the initial contact or call is made by the ***covered person,*** provider or ***authorized representative*** to the ***Utilization Review Organization,*** as specified in *Utilization Review.*

Post-service claims are those for which services have already been received (any claims other than ***pre-service claims***).

If the ***covered person*** would like the ***Third-Party Plan Administrator /claims processor*** to deal with someone other than them regarding a claim for benefits, then the ***covered person*** must provide the ***Third-Party Plan Administrator*** with a written authorization in order for an ***authorized representative*** (other than the ***Employee***) to represent and act on behalf of the ***covered person.*** The ***covered person*** must consent to release information related to the claim to the ***authorized representative.***

FILING A PRE-SERVICE CLAIM

A ***pre-service claim*** begins when the ***covered person,*** provider, or the ***covered person's authorized representative*** makes a call to the ***Utilization Review Organization*** to precertify specified services, supplies, or treatment. See *Utilization Review* for specific details regarding the services which require pre-certification, the number to call, and time frames for making the pre-certification call.

If a call is made to the ***Utilization Review Organization*** that fails to follow the pre-certification procedure as specified in *Utilization Review,* but at least identifies the name of the patient, a specific medical condition or symptom, and the specific treatment, service, or product for which pre-certification is being requested, the ***covered person*** or the ***covered person's authorized representative*** will be orally notified (in writing, if requested) within five (5) calendar days (twenty-four (24) hours in the case of Urgent Care Claims) of the failure to follow correct procedures.

Pre-service claims fall into three categories: Pre-certification Claims, Urgent Care Claims, or Concurrent Care Claims.

1. A Pre-certification Claim is a claim for any services for which the ***Plan*** requires pre-certification, however, the services which are required are not services which would qualify as Urgent Care Claims, as defined below.

2. Urgent Care Claims are claims for services which require pre-certification, however, the services are of such a nature such that the application of the longer time periods for making Pre-certification Claim determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or – in the opinion of a ***physician*** with knowledge of the patient's medical condition – would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

3. Concurrent Care Claims are claims for continuing care for which additional services are being requested or claims for which benefits for additional care are being reduced or terminated.

TIME FRAME FOR BENEFIT DETERMINATION OF A PRE-SERVICE CLAIM

When a ***pre-service claim*** has been submitted to the ***Plan*** (call made to the ***Utilization Review Organization***) and no additional information is required, the ***Plan*** will generally complete its determination of the claim within the following timeframes:

1. Pre-certification Claims – within a reasonable time frame, but no later than fifteen (15) calendar days from receipt of claim;

2. Urgent Care Claims – within a reasonable time frame, but no later than seventy-two (72) hours following receipt of claim;

3. Concurrent Care Claims – if a request for an extension of an on-going course of treatment is received, determination will be made as follows:

    a. If the request for additional care is of an urgent care nature and the request is made at least twenty-four (24) hours prior to the end of the course of treatment, the determination must be made within twenty-four (24) hours of the request. If the request is made less than twenty-four (24) hours prior to the end of the course of treatment, the determination must be made within seventy-two (72) hours of the request;

    b. For non-urgent care, the determination must be made within fifteen (15) calendar days after the request is received.

When a ***pre-service claim*** has been submitted to the ***Plan*** and additional information is needed in order to determine whether, and to what extent, services are covered or benefits are payable by the ***Plan,*** then the ***Third-Party Plan Administrator*** or its designee (***Utilization Review Organization***), shall notify the ***covered person*** as follows:

1. If the ***pre-service*** claim is for care of an urgent care nature, the ***Third-Party Plan Administrator*** or its designee shall notify the ***covered person*** as soon as possible, but no later than twenty-four (24) hours after the initial call, of the specific information necessary to complete the claim. The ***covered person*** or ***authorized representative*** will have forty-eight (48) hours to provide the requested information and the ***Third-Party Plan Administrator*** or its designee will complete the claim determination no later than forty-eight (48) hours after receipt of the requested information. Failure of the ***covered person*** to respond in a timely and complete manner will result in a denial of the pre-certification request.

2. If the ***pre-service claim*** is for non-urgent care or if an extension of time is required due to reasons beyond the control of the ***Third-Party Plan Administrator*** or its designee**,** the ***Third-Party Plan Administrator*** or its ***designee*** will, within fifteen (15) calendar days from the date of the initial call, provide the ***covered person*** or the ***covered person's authorized representative*** with a notice detailing the circumstances and the date by which the ***Third-Party Plan Administrator,*** or its designee, expects to render a decision. If additional information is required, the notice will provide details of what information is needed and the ***covered person*** will have forty-five (45) days to provide the requested information. The ***Third-Party Plan Administrator,*** or its designee, will complete its determination of the claim no later than fifteen (15) calendar days following receipt of the requested information. Failure to respond in a timely and complete manner will result in a denial of the pre-certification request.

NOTICE OF PRE-SERVICE CLAIM BENEFIT DENIAL

If the ***pre-service claim*** for benefits is denied, the ***Third-Party Plan Administrator*** or its designee shall provide the ***covered person*** or authorized representative with a written notice of benefit denial within the timeframes listed above.

The notice will contain the following:

1. Explanation of the denial, including:

    a. The specific reasons for the denial;
    b. Reference to the ***Plan*** provisions on which the denial is based;
    c. A description of any additional material or information necessary and an explanation of why such material or information is necessary;
    d. A description of the ***Plan's*** review procedure and applicable time limits;
    e. A statement that if the ***covered person's*** appeal (See "Appealing a Denied Pre-Service Claim" below) is denied, the ***covered person*** has the right to bring a civil action under Section 502 (a) of the Employee Retirement Income Security Act of 1974. If you disagree with the decision of the Board of Trustees, you may initiate arbitration by written request to any office of the American Arbitration Association within 60 days after you received the Board of Trustees' decision. The request for arbitration must be accompanied by a copy of the denial of the claim. The arbitration will be conducted in accordance with the Association's rules, a copy of which will be provided to you. The Trustees, Participants, Beneficiaries, and Employers subject to this Plan each agree to be bound by the decision of the arbitrator.

2. If an internal rule, guideline, protocol, or other similar criterion was relied upon, the Notice will contain either

    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

3. If denial was based on ***medical necessity***, ***experimental*** treatment, or similar exclusion or limit, the ***Plan*** will supply either

    a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED PRE-SERVICE CLAIM

The Named Fiduciary for purposes of an appeal of a ***pre-service claim*** as described in U. S. Department of Labor Regulations 2560.503-1 is the ***Board of Trustees***.

A ***covered person*****,** or the ***covered person's authorized representative***, may request a review of a denied claim by making written (for any claim involving urgent care, the request may be verbal) request to the Named Fiduciary within sixty (60) calendar days from receipt of notification of the denial. The written request should state the reasons the ***covered person*** feels the claim should not have been denied. The following describes the review process:

1. The ***covered person*** has a right to submit documents, information, and comments.

2. The ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits. Relevant information is defined as any document, record, or other information:

a. Relied on in making the benefit determination; or
b. That was submitted, considered, or generated in the course of making a benefit determination, whether or not relied upon; or
c. That demonstrates compliance with the duties to make benefit decisions in accordance with Plan documents and to make consistent decisions; or
d. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

3. The review shall take into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

4. The review by the Named Fiduciary will not afford deference to the original denial.

5. The Named Fiduciary will not be:

    a. The individual who originally denied the claim, nor
    b. Subordinate to the individual who originally denied the claim.

6. If the original denial was, in whole or in part, based on medical judgment:

    a. The Named Fiduciary will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
    b. The ***professional provider*** utilized by the Named Fiduciary will be neither:
        (1) An individual who was considered in connection with the original denial of the claim, nor
        (2) A subordinate of any other ***professional provider*** who was considered in connection with the original denial.
    c. If requested, the Named Fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION FOR PRE-SERVICE CLAIMS ON APPEAL

The Named Fiduciary shall provide the ***covered person*** or authorized representative with a written notice of the appeal decision within the following timeframes:

1. Urgent Care Claims or Concurrent Care Claims involving urgent care – as soon as possible, but not later than seventy-two (72) hours from receipt of appeal;

2. Pre-certification Claims or Concurrent Care Claims involving non-urgent care – as soon as possible, but not later than fifteen (15) calendar days from receipt of appeal;

If the appeal is denied, the notice will contain the following:

1. Explanation of the denial including:

    a. The specific reasons for the denial.
    b. Reference to specific ***Plan*** provisions on which the denial is based.
    c. A statement that the ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits.

d. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under Section 502 (a) of the Employee Retirement Income Security Act of 1974. If you disagree with the decision of the Board of Trustees, you may initiate arbitration by written request to any office of the American Arbitration Association within 60 days after you received the Board of Trustees' decision. The request for arbitration must be accompanied by a copy of the denial of the claim. The arbitration will be conducted in accordance with the Association's rules, a copy of which will be provided to you. The Trustees, Participants, Beneficiaries, and Employers subject to this Plan each agree to be bound by the decision of the arbitrator.

2. If an internal rule, guideline, protocol, or other similar criterion was relied upon the Notice will contain either:

   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

3. If the denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, the Notice will supply either:

   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

FILING A POST-SERVICE CLAIM

1. A claim form is to be completed on each covered family member for each claim involving an ***injury***. Appropriate claim forms are available from the ***claims processor***.

   Claims should be submitted to the address shown on their identification card.

2. All bills submitted for benefits must contain the following:

   a. Name of patient.
   b. Patient's date of birth.
   c. Name of ***Employee.***
   d. Address of ***Employee.***
   e. Name of ***Employer.***
   f. Name, address, and tax identification number of provider.
   g. ***Employee*** Social Security number.
   h. Date of service.
   i. Diagnosis.
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the accident***, injury*** or ***illness*** being treated.

3. Properly completed claims not submitted within twelve (12) months of the date of incurred liability will be denied.

The ***covered person*** may ask the provider to submit the bill directly to the ***claims processor,*** or the ***covered person*** may file the bill with a claim form. However, it is ultimately the ***covered person's*** responsibility to make sure the claim has been filed for benefits.

TIME FRAME FOR BENEFIT DETERMINATION OF A POST-SERVICE CLAIM

When a completed claim has been submitted to the ***claims processor*** and no additional information is required, the ***claims processor*** will generally complete its determination of the claim within thirty (30) calendar day of receipt of the completed claim, unless an extension of time is necessary due to circumstances beyond the ***Plan's*** control.

When a completed claim has been submitted to the ***claims processor*** and additional information is required for determination of the claim, the ***claims processor*** will provide the ***covered person*** or ***authorized representative*** with a notice detailing the information needed. This notice will be provided within thirty (30) calendar days of receipt of the completed claim and will indicate the date when the ***claims processor*** expects to make a decision, if the requested information is received. The ***covered person*** will have forty-five (45) calendar days to provide the information requested, and the ***claims processor*** will complete its determination of the claim within fifteen (15) calendar days of receipt of the requested information**.** Failure to respond in a timely and complete manner will result in a denial of benefit payment.

NOTICE OF POST-SERVICE CLAIM BENEFIT DENIAL

If the ***post-service*** claim for benefits is denied, the ***Third-Party Plan Administrator*** or their designee shall provide the ***covered person*** or ***authorized representative*** with a written notice of benefit denial within thirty (30) calendar days of receipt of a completed claim, or if the ***Plan*** had requested additional information from the ***covered person*** or ***authorized representative***, within fifteen (15) calendar days of receipt of such information. The notice will contain the following:

1. Explanation of the denial, including:

    a. The specific reasons for the denial.
    b. Reference to the ***Plan*** provisions on which the denial is based.
    c. A description of any additional material or information necessary and an explanation of why such material or information is necessary.
    d. A description of the ***Plan's*** review procedure and applicable time limits.
    e. A statement that if the ***covered person's*** appeal (See "Appealing a Denied Post-Service Claim" below) is denied, the ***covered person*** has the right to bring a civil action under Section 502 (a) of the Employee Retirement Income Security Act of 1974. If you disagree with the decision of the Board of Trustees, you may initiate arbitration by written request to any office of the American Arbitration Association within 60 days after you received the Board of Trustees' decision. The request for arbitration must be accompanied by a copy of the denial of the claim. The arbitration will be conducted in accordance with the Association's rules, a copy of which will be provided to you. The Trustees, Participants, Beneficiaries, and Employers subject to this Plan each agree to be bound by the decision of the arbitrator.

2. If an internal rule, guideline, protocol, or other similar criterion was relied upon, the Notice will contain either

    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

3. If the denial was based on ***medical necessity***, ***experimental*** treatment or similar exclusion or limit, the ***Plan*** will supply either:

    a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or

b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED POST-SERVICE CLAIM

The "Named Fiduciary" for purposes of an appeal of a ***post-service claim*** as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000) is the ***Board of Trustees***.

A ***covered person*****,** or the ***covered person's authorized representative***, may request a review of a denied claim by making written request to the "Named Fiduciary" within sixty (60) calendar days from receipt of notification of the denial. The request for review should state the reasons the ***covered person*** feels the claim should not have been denied.

The review process is as follows:

1. The ***covered person*** has a right to submit documents, information, and comments.

2. The ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits. Relevant information is defined as any document, record, or other information:

    a. Relied on in making the benefit determination, OR
    b. That was submitted, considered, or generated in the course of making a benefit determination, whether or not relied upon, OR
    c. That demonstrates compliance with the duties to make benefit decisions in accordance with ***Plan*** documents and to make consistent decisions, OR
    d. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

3. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

4. The review by the Named Fiduciary will not afford deference to the original denial.

5. The Named Fiduciary will not be:

    a. The individual who originally denied the claim, nor
    b. Subordinate to the individual who originally denied the claim.

6. If original denial was, in whole or in part, based on medical judgment,

    a. The Named Fiduciary will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
    b. The ***professional provider*** utilized by the Named Fiduciary will be neither:
        (1) An individual who was considered in connection with the original denial of the claim, nor
        (2) A subordinate of any other ***professional provider*** who was considered in connection with the original denial.
    c. If requested, the Named Fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION FOR POST-SERVICE CLAIM APPEAL

The ***Third-Party Plan Administrator*** or their designee shall provide the ***covered person*** or ***authorized representative*** with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal. If the appeal is denied, the notice will contain the following:

1. An explanation of the denial including:

    a. The specific reasons for the denial.
    b. Reference to specific ***Plan*** provisions on which the denial is based.
    c. A statement that the ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits.
    d. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under Section 502 (a) of the Employee Retirement Income Security Act of 1974. If you disagree with the decision of the Board of Trustees, you may initiate arbitration by written request to any office of the American Arbitration Association within 60 days after you received the Board of Trustees' decision. The request for arbitration must be accompanied by a copy of the denial of the claim. The arbitration will be conducted in accordance with the Association's rules, a copy of which will be provided to you. The Trustees, Participants, Beneficiaries, and Employers subject to this Plan each agree to be bound by the decision of the arbitrator.

2. If an internal rule, guideline, protocol, or other similar criterion was relied upon, the Notice will contain either:

    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

3. If the denial was based on ***medical necessity***, ***experimental*** treatment, or similar exclusion or limit, the ***Plan*** will supply either:

    a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the patient's medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

FOREIGN CLAIMS

In the event a ***covered person*** incurs a ***covered expense*** in a foreign country, the ***covered person*** shall be responsible for providing the following to the ***claims processor*** before payment of any benefits due are payable:

1. The claim form, provider invoice, and any other documentation required to process the claim must be submitted in the English language.

2. The charges for services must be converted into dollars.

3. A current conversion chart validating the conversion from the foreign country's currency into dollars.

INDEPENDENT REVIEW OF DENIED APPEAL

(Only applies to decisions involving medical judgements)

Once your appeal rights as described above are exhausted, you may request an independent external review unless the denial, reduction, termination, or a failure to provide payment for a benefit was based on a determination that you or your Dependent or Beneficiary failed to meet the requirements for eligibility under the Plan. The following procedures will apply:

1. If the Trustees deny your claim, you may file a request for external review within four (4) months of the claim denial.

2. Within five (5) business days of receiving the request for external review, the Fund Office will complete a preliminary review regarding your eligibility for coverage and exhaustion of internal appeals. If your request does not satisfy the preliminary review elements, the Fund Office must notify you within one (1) business day after the preliminary review. If the request is incomplete, you will have at least 48 hours or up to the initial four (4) month period, to perfect the request for external review. If the request for external review is expedited, the Fund Office must respond immediately.

3. The Fund has contracted with three (3) unbiased accredited Independent Review Organizations (IROs) which require the IROs to perform each of the following:
    a. Use legal experts when appropriate.
    b. Timely contact you in writing with information about the review, including how to submit additional information.
    c. To consider documentation provided by the Fund Office that is relevant to your claim. The Fund Office must submit this material within five (5) business days of the request for external review or, for an expedited review, as soon as possible.
    d. To review your claim *de novo*, considering all relevant available information, including applicable practice standards and opinion from the IRO's own clinical reviewers. The IRO must send written notice of its decision to you and to the Fund Office within 45 days of the request for external review. Notice of the decision must explain the potential for judicial review.

4. The Fund must rotate external review assignments among the contracted IROs.

5. If the IRO reverses a claim denial, the Fund must immediately cover the claim. The IRO's decision is binding on the Fund.

COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the ***covered person*** is also covered by any Other Plan(s). When more than one coverage exists, one Plan normally pays its benefits in full, referred to as the primary Plan. The Other Plan(s), referred to as the secondary Plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all Plans will not exceed 100% of "allowable expenses." Only the amount paid by this ***Plan*** will be charged against the ***maximum benefit.***

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another Plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while covered under this ***Plan,*** part or all of which would be covered under this ***Plan***. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this ***Plan.***

When this ***Plan*** is secondary, "Allowable Expense" will include any deductible or ***coinsurance*** amounts not paid by the Other Plan(s).

When this ***Plan*** is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary Plan as a result of a contract between the primary Plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the ***covered person*** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any Plan, policy, or coverage providing benefits or services for, or by reason of medical, dental, or vision care. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type Plans;

2. Hospital or medical service organization on a group basis, group practice, and other group prepayment Plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Individual automobile insurance coverage;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any Plan or policies funded in whole or in part by an ***employer,*** or deductions made by an ***employer*** from a person's compensation or retirement benefits;

10. Labor/management trustees, union welfare, employer organization, or Employee benefit organization Plans.

"This ***Plan"*** shall mean that portion of the ***Employer's Plan*** which provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the ***covered person*** for whom a claim is made has been covered under this ***Plan.***

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits paid under this ***Plan*** may be reduced so that the sum of benefits paid by all Plans does not exceed one hundred percent (100%) of total Allowable Expense.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan.***

AUTOMOBILE-RELATED INJURIES

The ***Plan*** will not provide primary coverage for medical expenses arising due to an automobile-related ***injury.*** In addition, the ***Plan*** allows only the ***maximum benefit*** specified on the *Schedule of Benefits* for medical expenses arising due to an automobile or other motor or recreational vehicle-related accident (e.g. automobiles, motorcycles, jet skis, all-terrain vehicles, etc.).

A ***covered person*** **should not** advise his or her automobile insurance carrier that he or she has alternative coverage under this ***Plan*** for medical claims arising from an accident. The ***Plan*** will pay these claims only on a secondary payor basis.

ORDER OF BENEFIT DETERMINATION

Each Plan will make its claim payment according to the following order of benefit determination:

1. No Coordination of Benefits Provision
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/Dependent
   The Plan which covers the claimant as a member (or named insured) pays as though no Other Plan existed. Remaining ***covered expenses*** are paid under a Plan which covers the claimant as a ***dependent.***

3. Dependent Children of Parents not Separated or Divorced
   The Plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The Plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the Plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply, instead:

   a. If a court decree has given one parent financial responsibility for the child's health care, the Plan of that parent pays first. The Plan of the stepparent married to that parent, if any, pays second. The Plan of the other natural parent pays third. The Plan of the spouse of the other natural parent pays fourth.

b. In the absence of such a court decree, the Plan of the parent with custody pays first. The Plan of the stepparent married to the parent with custody, if any, pays second. The Plan of the parent without custody pays third. The Plan of the spouse of the parent without custody pays fourth.

5. Active/Inactive
The Plan covering a person as an active (not laid off or retired) ***Employee,*** or as that person's ***dependent*** pays first. The Plan covering that person as a laid off or retired ***Employee,*** or as that person's ***dependent*** pays second.

6. Limited Continuation of Coverage
If a person is covered under another group health Plan but is also covered under this ***Plan*** for continuation of coverage due to the Other Plan's limitation for ***pre-existing conditions*** or exclusions, the Other Plan shall be primary for all ***covered expenses*** which are not related to the ***pre-existing condition*** or exclusions. This ***Plan*** shall be primary for the ***pre-existing condition*** only.

7. Longer/Shorter Length of Coverage
If none of the above rules determine the order of benefits, the Plan covering a person longer pays first. The Plan covering that person for a shorter time pays second.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s). Nothing contained in this section shall entitle the ***covered person*** to benefits in excess of the total ***maximum benefits*** of this ***Plan*** during the claim determination period. The ***covered person*** shall refund to the ***Trustees*** any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information with respect to any ***covered person.*** Any person claiming benefits under this ***Plan*** shall furnish to the ***Trustees*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***Trustees*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***Trustees*** shall be fully discharged from liability.

SUBROGATION

The ***Plan*** is designed to only pay ***covered expenses*** for which payment is not available from anyone else, including any insurance company or another health Plan. In order to help a ***covered person*** in a time of need, however, the ***Plan*** may pay ***covered expenses*** that may be or become the responsibility of another person, provided that the ***Plan*** later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the ***Plan***, as well as by applying for payment of ***covered expenses***, a ***covered person*** is subject to, and agrees to, the following terms and conditions with respect to the amount of ***covered expenses*** paid by the ***Plan***:

1. Assignment of Rights (Subrogation). The ***covered person*** automatically assigns to the ***Plan*** any rights the ***covered person*** may have to recover all or part of the same ***covered expenses*** from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts, and health savings accounts), but limited to the amount of Reimbursable Payments made by the ***Plan***. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a ***covered person*** or paid to another for the benefit of the ***covered person***. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the ***covered person*** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the ***Plan*** to pursue any claim that the ***covered person*** may have, whether or not the ***covered person*** chooses to pursue that claim. By this assignment, the ***Plan's*** right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The ***Plan*** shall have an equitable lien against any rights the ***covered person*** may have to recover the same ***covered expenses*** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the ***Plan***. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid ***covered expenses*** prior to a determination that the ***covered expenses*** arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the ***covered person***, the ***covered person's*** attorney, and/or a trust) as a result of an exercise of the ***covered person's*** rights of recovery (sometimes referred to as "proceeds"). The ***Plan*** shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the ***Third-Party Plan Administrator***, the ***Plan*** may reduce any future ***covered expenses*** otherwise available to the ***covered person*** under the ***Plan*** by an amount up to the total amount of Reimbursable Payments made by the ***Plan*** that is subject to the equitable lien.

   This and any other provisions of the ***Plan*** concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the ***Plan*** concerning subrogation, equitable liens, and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in ***Plan's*** Reimbursement Activities. The ***covered person*** has an obligation to assist the ***Plan*** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the ***covered person***, and to provide the ***Plan*** with any information concerning the ***covered person's*** other insurance coverage (whether through

automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the ***covered person***. The ***covered person*** is required to (a) cooperate fully in the ***Plan's*** (or any ***Plan*** fiduciary's) enforcement of the terms of the ***Plan***, including the exercise of the ***Plan's*** right to subrogation and reimbursement, whether against the covered person or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the ***Plan*** as a co-payee for the amount of the Reimbursable Payments and notifying the ***Plan***), (c) sign any document deemed by the ***Third-Party Plan Administrator*** to be relevant to protecting the ***Plan's*** subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the ***Third-Party Plan Administrator*** or ***claims processor*** to enforce the ***Plan***'s rights.

The ***Third-Party Plan Administrator*** has delegated to the ***claims processor*** the right to perform ministerial functions required to assert the ***Plan's*** rights, however, the ***Third-Party Plan Administrator*** shall retain discretionary authority with regard to asserting the ***Plan's*** recovery rights.

THIS PLAN AND MEDICARE

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for ***Medicare*** Part A at no cost. Participation in ***Medicare*** Part B and D is available to all individuals who make application and pay the full cost of the coverage.

1. When an ***Employee*** becomes entitled to ***Medicare*** coverage and is still actively at work, the ***Employee*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

2. When a ***dependent*** becomes entitled to ***Medicare*** coverage and the ***Employee*** is still actively at work**,** the ***dependent*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

3. If the ***Employee*** is also enrolled in ***Medicare,*** this ***Plan*** shall pay as the primary Plan. ***Medicare*** will pay as secondary Plan. If the Employee's dependent is also enrolled in Medicare, Medicare will pay as the primary Plan and this Plan shall pay as the secondary Plan.

4. If the ***Employee*** and/or ***dependent*** elect to discontinue health coverage under this ***Plan*** and enroll under the ***Medicare*** program, no benefits will be paid under this ***Plan.*** ***Medicare*** will be the only payor.

5. No benefits are provided to ***retirees*** under this ***Plan.***

This section is subject to the terms of the ***Medicare*** laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The ***Plan*** is administered through the Fund Office**.** The ***Trustees*** have full charge of the operation and management of the ***Plan.*** The ***Trustees*** have retained the services of an independent ***Third-Party Plan Administrator*** and its claims processors experienced in claims review.

The ***Third-Party Plan Administrator*** maintains the Fund Office and is responsible for the day-to-day operation of the ***Plan*** including claims processing and other administrative duties that have been delegated to it by the ***Trustees***. The ***Third-Party Plan Administrator*** acts at the direction of the ***Trustees***, who retain the sole and exclusive right to interpret the ***Plan***.

ASSIGNMENT

The ***Plan*** will pay benefits under this ***Plan*** to the ***Employee*** unless payment has been assigned to a ***hospital, physician,*** or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the ***Plan*** unless the ***claims processor*** is notified in writing of such assignment prior to payment hereunder.

Preferred providers normally bill the ***Plan*** directly. If services, supplies, or treatment have been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate,*** after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***preferred provider.***

This ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a Qualified Medical Child Support Order or National Medical Support Notice.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under this ***Plan.*** Such right to benefits is not transferable.

CLERICAL ERROR

No clerical error on the part of the ***Plan Sponsor*** or ***claims processor*** shall operate to defeat any of the rights, privileges, services, or benefits of any ***Employee*** or any ***dependent(s)*** hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the ***Plan*** which is in conflict with statutes which are applicable to this ***Plan*** is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The original ***effective date*** of this ***Plan*** was January 1, 1985. The ***effective date*** of the modifications contained herein is January 1, 2018

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this ***Plan*** shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a ***hospital*** or to make a free choice of the attending ***physician*** or ***professional provider.*** However, benefits will be paid in accordance with the provisions of this ***Plan,*** and the ***covered person*** will have higher out-of-pocket expenses if the ***covered person*** uses the services of a ***non-preferred provider.***

INCAPACITY

If, in the opinion of the ***Third-Party Plan Administrator,*** a ***covered person*** for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the ***Plan*** of the qualification of a guardian or personal representative for his estate, the ***Third-Party Plan Administrator*** may on behalf of the ***Plan,*** at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the ***Plan's*** obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the ***Third-Party Plan Administrator*** or by the ***Employee*** covered under this ***Plan*** shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this ***Plan*** or be used in defense to a claim unless they are contained in writing and signed by the ***Third-Party Plan Administrator*** or by the ***covered person,*** as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the ***Plan*** prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the ***Plan.*** No such action shall be brought after the expiration of two (2) years from the date the expense was ***incurred,*** or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the ***Third-Party Plan Administrator*** shall not be liable for any obligation of the ***covered person incurred*** in excess thereof. The ***Third-Party Plan Administrator*** shall not be liable for the negligence, wrongful act, or omission of any ***physician, professional provider, hospital,*** or other institution, or their Employees, or any other person. The liability of the ***Plan*** shall be limited to the reasonable cost of ***covered expenses*** and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the ***Third-Party Plan Administrator*** is unable to locate the ***covered person*** to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the ***covered person*** for the forfeited benefits within the time prescribed in *Claim Filing Procedure.*

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The ***Plan*** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State Plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a ***covered person*** or in determining or making any payment of benefits to that individual. The ***Plan*** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid Plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this ***Plan*** has a legal liability to make payments for the same services, supplies, or treatment, payment under the ***Plan*** will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies, or treatment under the ***Plan.***

MISREPRESENTATION

If the ***covered person*** or anyone acting on behalf of a ***covered person*** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the ***Plan,*** or otherwise misleads the ***Plan,*** the ***Plan*** shall be entitled to recover its damages, including legal fees, from the ***covered person,*** or from any other person responsible for misleading the ***Plan,*** and from the person for whom the benefits were provided. Any material misrepresentation on the part of the ***covered person*** in making application for coverage, or any application for reclassification thereof, or for service there under shall render the coverage under this ***Plan*** null and void.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The ***Plan,*** at its own expense, shall have the right to require an examination of a person covered under this ***Plan*** when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The ***Plan*** shall not be deemed to constitute a contract between the ***Third-Party Plan Administrator*** or ***Employer*** and any ***Employee*** or to be a consideration for, or an inducement or condition of, the employment of any ***Employee.*** Nothing in the ***Plan*** shall be deemed to give any ***Employee*** the right to be retained in the service of the ***Third-Party Plan Administrator*** or ***Employer*** or to interfere with the right of the ***Third-Party Plan Administrator*** or ***Employer*** to terminate the employment of any ***Employee*** at any time.

PLAN MODIFICATION AND AMENDMENT

The ***Board of Trustees*** may modify or amend the ***Plan*** from time to time in accordance with the provision of the collective bargaining agreement, and such amendments or modifications which affect ***covered persons*** will be

communicated to the ***covered persons.*** Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan,*** the ***effective date*** of the modifications, and shall be signed by the ***Board of Trustees'*** designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***Third-Party Plan Administrator,*** or a written copy thereof shall be deposited with such master copy of the ***Plan.*** Appropriate filing and reporting of any such modification or amendment with governmental authorities and to ***covered persons*** shall be timely made by the ***Third-Party Plan Administrator.***

PLAN TERMINATION

The ***Board of Trustees*** reserves the right to terminate the ***Plan*** at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons.***

Upon termination of this ***Plan,*** all claims ***incurred*** prior to termination, but not submitted to either the ***Third-Party Plan Administrator*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan,*** will be excluded from any benefit consideration.

PRONOUNS

All personal pronouns used in this ***Plan*** shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the ***Plan*** in excess of the maximum amount of payment necessary, the ***Plan*** will have the right to recover these excess payments. If the company makes any payment that, according to the terms of the ***Plan,*** should not have been made, the ***Plan*** may recover that incorrect payment, whether or not it was made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

STATUS CHANGE

If an ***Employee*** or ***dependent*** has a status change while covered under this ***Plan*** (i.e. ***dependent*** to ***Employee,*** COBRA to Active) and no interruption in coverage has occurred, the ***Plan*** will provide continuance of coverage with respect to any ***pre-existing condition*** limitation, deductible(s), ***coinsurance,*** and ***maximum benefit.***

TIME EFFECTIVE

The effective time with respect to any dates used in the ***Plan*** shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the ***Third-Party Plan Administrator.***

WORKERS' COMPENSATION NOT AFFECTED

This ***Plan*** is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

DISCRETIONARY AUTHORITY

The Board of Trustees (or its designee) has the exclusive right, power and authority, in its sole and absolute discretion, to administer, apply and interpret this Plan and to decide all matters arising in connection with the operation or administration of the Plan.

Without limiting the generality of the foregoing, the Board (or its designee) has the sole and absolute discretionary authority to:

- take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan to participants or their beneficiaries;
- formulate, interpret and apply rules, regulations and policies necessary to administer the Plan or other Plan documents in accordance with their terms and to interpret and apply the provisions of the collective bargaining agreements;
- decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan or other Plan documents;
- resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other Plan documents;
- process, and approve or deny, benefit claims and rule on any benefit exclusions; and
- decide questions as to whether services rendered are services covered under the Plan.

All determinations made by the Board (or its designee) with respect to any matter arising under the Plan and any other Plan documents shall be final and binding.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Alternate Recipient
Any child of an ***Employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan.***

Ambulatory Surgical Facility
A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., or by the ***Plan,*** which:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;

2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility;***

3. Does not provide ***inpatient*** accommodations; and

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a ***physician.***

Authorized Representative
An individual who the ***covered person*** has authorized (in writing) to represent or act on their behalf with regards to a claim. An assignment of benefits does not constitute a written authorization for a provider to act as an ***authorized representative*** of a ***covered person.***

Birthing Center
A ***facility*** that meets professionally recognized standards and all of the following tests:

1. It mainly provides an ***outpatient*** setting for childbirth following a normal, uncomplicated ***pregnancy,*** in a home-like atmosphere.

2. It has: (a) at least two (2) delivery rooms; (b) all the medical equipment needed to support the services furnished by the facility; (c) laboratory diagnostic facilities; and (d) emergency equipment, trays, and supplies for use in life threatening situations.

3. It has a medical staff that: (a) is supervised full-time by a ***physician;*** and (b) includes a registered nurse at all times when ***covered persons*** are at the facility.

4. If it is not part of a ***hospital,*** it has written agreement(s) with a local ***hospital(s)*** and a local ambulance company for the immediate transfer of ***covered persons*** who develop complications or who require either pre or post-natal care.

5. It admits only ***covered persons*** who: (a) have undergone an educational program to prepare them for the birth; and (b) have medical records of adequate prenatal care.

6. It schedules ***confinements*** of not more than twenty-four (24) hours for a birth.

7. It maintains medical records for each ***covered person.***

8. It complies with all licensing and other legal requirements that apply.

9. It is not the office or clinic of one or more ***physicians*** or a specialized ***facility*** other than a ***birthing center.***

Chemical Dependency
A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria.

Chiropractic Care
Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities, or other joints, other than for a fracture or surgery.

Claims Processor
The company contracted by the ***Plan Sponsor*** which is responsible for the processing of claims for benefits under the terms of the ***Plan*** and other ministerial services deemed necessary for the operation of the ***Plan*** as delegated by the ***Plan Sponsor.***

Close Relative
The ***Employee's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters, or parents of the ***Employee's*** spouse.

Coinsurance
The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan.*** The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

Complications of Pregnancy
A disease, disorder, or condition which is diagnosed as distinct from ***pregnancy,*** but is adversely affected by or caused by ***pregnancy.*** Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).

2. Ectopic ***pregnancy.***

3. Toxemia with convulsions (Eclampsia).

4. Pernicious vomiting (hyperemesis gravidarum).

5. Nephrosis.

6. Cardiac Decompensation.

7. Missed Abortion.

8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even if prescribed by a ***physician;*** morning sickness; or like conditions that are not medically termed as ***complications of pregnancy.***

Concurrent Review
A review by the ***Utilization Review Organization*** which occurs during the ***covered person's hospital confinement*** to determine if continued ***inpatient*** care is ***medically necessary.***

Confinement
A continuous stay in a ***hospital, treatment center, extended care facility, hospice,*** or ***birthing center*** due to an ***illness*** or ***injury*** diagnosed by a ***physician.*** Later stays shall be deemed part of the original ***confinement*** unless there was either complete recovery during the interim from the ***illness*** or ***injury*** causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the ***illness*** or ***injury*** causing the initial stay. With respect to an ***Employee,*** if the ***Employee*** has returned to work for at least one (1) full working day, additional ***confinements*** will not be considered part of the original ***confinement***. With respect to a ***dependent*** only, if ***hospital confinements*** are separated by a period of ninety (90) days, each ***confinement*** will be considered a new ***confinement***.

Co-pay
A cost sharing arrangement whereby a ***covered person*** pays a set amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery
Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Covered Expenses
Medically necessary services, supplies, or treatments that are recommended or provided by a ***physician, professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person
A person who is eligible for coverage under this ***Plan,*** or becomes eligible at a later date, and for whom the coverage provided by this ***Plan*** is in effect.

Custodial Care
Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury.*** ***Custodial care*** includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended, or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under this ***Plan,*** and (2) if combined with other necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition.

Customary and Reasonable Amount
The fee assessed by a provider of service for services, supplies, or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies, or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury.*** Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill, or experience. The ***customary and reasonable amount*** is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply, or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges.

Dentist
A licensed Doctor of Dental Medicine (D.M.D.) or a licensed Doctor of Dental Surgery (D.D.S.), other than a ***close relative*** of the ***covered person.***

Dependents
For a complete definition of ***dependent,*** refer to *Eligibility, Dependent Eligibility.*

Durable Medical Equipment
Medical equipment which:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;

3. Is generally not used in the absence of an ***illness*** or ***injury;***

4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered ***durable medical equipment. Durable medical equipment*** includes, but is not limited to: crutches, wheel chairs, ***hospital*** beds, etc.

Effective Date
The date of this ***Plan*** or the date on which the ***covered person's*** coverage commences, whichever occurs later.

Emergency
The sudden onset of an ***illness*** or ***injury*** where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

1. Placing the ***covered person's*** life in jeopardy, or

2. Causing other serious medical consequences, or

3. Causing serious impairment to bodily functions, or

4. Causing serious dysfunction of any bodily organ or part.

Employee
A person covered by a collective bargaining agreement between the ***Union*** and the ***Employer***, or by any other agreement which requires contributions on their behalf to the ***Fund***.

Employer
Any employer who now or hereafter has a collective bargaining agreement with the ***Union*** requiring periodic contributions to the ***Fund*** and who is accepted into participation by the ***Trustees***; or any employer who now or hereafter has a written agreement with the ***Fund*** requiring periodic contributions to the ***Fund***; or the ***Union*** for all its full-time salaried Employees.

Experimental/Investigational
Services, supplies, and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The ***claims processor,*** Named Fiduciary, ***Third-Party Plan Administrator***, or their designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The ***claims processor,*** Named Fiduciary, ***Third-Party Plan Administrator***, or their designee shall be guided by a reasonable interpretation of ***Plan*** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***claims processor,*** Named Fiduciary, ***Third-Party Plan Administrator***, or their designee will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment, or procedure, or the ***covered person*** informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If "reliable evidence" shows that the drug, device, medical treatment, or procedure is the subject of on-going phase I or phase II clinical trials, is in the research, experimental study, or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with a standard means of treatment or diagnosis; or

4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Extended Care Facility
An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury,*** professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a registered nurse.

2. Its services are provided for compensation from its ***covered persons*** and under the full-time supervision of a ***physician*** or Registered Nurse.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each ***covered person.***

5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of ***mental and nervous disorders.***

6. It is approved and licensed by ***Medicare.***

This term shall also apply to expenses ***incurred*** in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility
A healthcare institution which meets all applicable state or local licensure requirements, such as a freestanding dialysis ***facility,*** a lithotriptor center, or an outpatient-imaging center.

Fund
The ***Fund*** is the Teamsters Local Union 966 Health Fund.

Generic Drug
A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Habilitative Services
Health care services that help a person keep, learn or improve skills and functioning for daily living, for example therapy for a child who isn't walking or talking at the expected age.

Home Health Aide Services
Those services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care Agency
An agency or organization which meets fully every one of the following requirements:

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

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

3. It maintains a complete medical record on each ***covered person.***

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under ***Medicare.***

Hospice
An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.

3. It is under the direct supervision of a ***physician.***

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of ***hospice*** services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the ***covered person.***

9. It is licensed, if licensing is required.

Hospital
An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals.***

2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury;*** and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.

4. It qualifies as a ***hospital*** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

5. It must be approved by ***Medicare.***

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for rehabilitative services where the ***covered person*** received treatment as a result of an ***illness*** or ***injury.***

The term ***hospital,*** when used in conjunction with ***inpatient confinement*** for mental and nervous conditions or ***chemical dependency,*** will be deemed to include an institution which is licensed as a mental ***hospital*** or ***chemical dependency*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness
A bodily disorder, disease, physical sickness, or ***pregnancy*** of a ***covered person.***

Incurred or Incurred Date
With respect to a ***covered expense,*** the date the services, supplies, or treatment are provided.

Injury
A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound.

Inpatient
A ***confinement*** of a ***covered person*** in a ***hospital, hospice,*** or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board.***

Intensive Care
A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician.***

Intensive Care Unit
A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care.*** It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital;***

2. Special life-saving equipment which is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and

4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room.

Maximum Benefit
Any one of the following, or any combination of the following:

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** during the entire time he is covered by this ***Plan.***

2. The maximum amount paid by this ***Plan*** for any one ***covered person*** for a particular ***covered expense.*** The maximum amount can be for:

   a. The entire time the ***covered person*** is covered under this ***Plan,*** or
   b. A specified period of time, such as a calendar year.

3. The maximum number the ***Plan*** acknowledges as a ***covered expense.*** The maximum number relates to the number of:

   a. Treatments during a specified period of time, or
   b. Days of ***confinement*** **in an extended care facility**

   The ***maximum benefit*** payable on behalf of a ***covered person*** is shown on the *Schedule of Benefits.* The ***maximum benefit*** applies to the entire time the ***covered person*** is covered under the ***Plan,*** either as an ***Employee, dependent, alternate recipient,*** or under COBRA. If the ***covered person's*** coverage under the ***Plan*** terminates and at a later date he again becomes covered under the ***Plan,*** the ***maximum benefit*** will include all benefits paid by the ***Plan*** for the ***covered person*** during any period of coverage.

   The *Schedule of Benefits* contains separate ***maximum benefit*** limitations for specified conditions. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the ***covered person*** during any and all periods of coverage under this ***Plan.*** All separate ***maximum benefits*** are part of, and not in addition to, the ***maximum benefit.*** No more than the ***maximum benefit*** will be paid for any ***covered person*** while covered by this ***Plan.***

Medically Necessary (Medical Necessity)
Service, supply, or treatment which, as determined by the ***claims processor, Third-Party Plan Administrator,*** or their designee, to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered; and

2. Supplied or performed in accordance with current standards of good medical practice within the United States; and

3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider***; and

4. Is an appropriate supply or level of service that safely can be provided; and

5. It is recommended or approved by the attending ***professional provider.***

The fact that a ***professional provider*** may prescribe, order, recommend, perform, or approve a service, supply, or treatment does not, in and of itself, make the service, supply, or treatment ***medically necessary.*** In making the determination of whether a service or supply was ***medically necessary,*** the ***claims processor, Third-Party Plan Administrator***, or its designee, may request and rely upon the opinion of a ***physician*** or ***physicians.*** The determination of the ***claims processor, Board of Trustees***, or its designee shall be final and binding.

Medicare
The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding both programs, and Part D – Prescription Drug Benefits; and including any subsequent changes or additions to those programs.

Mental and Nervous Disorder
An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Negotiated Rate
The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan.***

Nonparticipating Pharmacy
Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy.***

Non-preferred Provider
A ***physician, hospital,*** or other health care provider which does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse
A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Outpatient
A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient***;

2. A ***physician's*** office, laboratory or x-ray ***facility***; or

3. An ***ambulatory surgical facility***; and

The stay is less than twenty-three (23) consecutive hours.

Partial Confinement
A period of less than twenty-four (24) hours of active treatment in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.

2. Treatment of ***mental and nervous disorders.***

3. ***Chemical dependency*** treatment.

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy
Any pharmacy licensed to dispense prescription drugs which is contracted within the ***Pharmacy Organization***.

Pharmacy Organization
An organization who selects and contracts with certain pharmacies to provide ***covered persons*** prescription medications at a ***negotiated rate.*** The ***Pharmacy Organization*** is EnvisionRx.

Physician
A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is practicing within the scope of his license.

Placed For Adoption
The date the ***Employee*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan
"Plan" refers to the benefits and provisions for payment of same as described herein.

Third-Party Plan Administrator (TPA)
The ***Third-Party Plan Administrator*** is designated by the ***Trustees*** and is responsible for the day-to-day functions and management of the ***Plan.*** The ***Third-Party Plan Administrator*** is Benesys, Inc.

Plan Sponsor
The ***Plan Sponsor*** is the Board of Trustees of the Teamsters Local Union 966 Health Fund.

Post-service Claim
Post-service claims are those for which services have already been received (any claims other than ***pre-service claims***).

Pre-existing Conditions
An ***illness*** or ***injury*** which existed within six (6) months before the ***covered person's*** enrollment date for coverage under this ***Plan.*** An ***illness*** or ***injury*** is considered to have existed when the ***covered person:***

1. Sought or received professional advice for that ***illness*** or ***injury***, or

2. Received medical care or treatment for that ***illness*** or ***injury***, or

3. Received medical supplies, drugs, or medicines for that ***illness*** or ***injury***.

Preferred Provider
A ***physician, hospital*** or other health care ***facility*** who has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered. ***Preferred providers*** agree to accept the ***negotiated rate*** as payment in full.

Preferred Provider Organization
An organization who selects and contracts with certain ***hospitals, physicians,*** and other health care providers to provide ***covered persons*** services, supplies, and treatment at a ***negotiated rate.*** The ***Preferred Provider Organization*** is MagnaCare.

Pregnancy
The physical state which results in childbirth or miscarriage.

Pre-service Claim
A ***pre-service claim*** is a claim for services for which preapproval must be received before services are rendered in order for benefits to be payable under this ***Plan***, such as those services listed in the section *Utilization Review.* A ***pre-service claim*** is considered to be filed whenever the initial contact or call is made by the ***covered person***, provider, or ***authorized representative*** to the ***Utilization Review Organization***, as specified in *Utilization Review.*

Professional Provider
A person or other entity licensed where required and performing services within the scope of such license. The covered ***professional providers*** include, but are not limited to:

Acupuncturist
Certified Registered Nurse Anesthetist
Certified Registered Nurse Practitioner
Chiropractor
Clinical Laboratory
Dietician
Dispensing optician
Nurse (R.N., L.P.N., L.V.N.)
Optician
Optometrist
Physical Therapist
Physician
Physician's Assistant
Podiatrist
Psychologist
Respiratory Therapist

Rehabilitative Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired due to illness, injury or disability.

Retiree
A former ***Employee*** who retired from service of the ***Employer***. Retirees are not eligible for coverage under this ***Plan.***

Retrospective Review
A review by the ***Utilization Review Organization*** after the ***covered person's*** discharge from ***hospital confinement*** to determine if, and to what extent, ***inpatient*** care was ***medically necessary.***

Room and Board
Room and linen service, dietary service, including meals, ***medically necessary*** special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Semiprivate
The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in its ***semiprivate*** rooms containing two (2) or more beds.

Total Disability or Totally Disabled
The ***Employee*** is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

Treatment Center
1. An institution which does not qualify as a ***hospital,*** but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency*** or ***mental and nervous disorders***, and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    b. It provides a program of treatment approved by the ***physician.***
    c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person.***
    d. It provides at least the following basic services:
        (1) ***Room and board***
        (2) Evaluation and diagnosis
        (3) Counseling
        (4) Referral and orientation to specialized community resources.

Trustees
The ***Trustees*** are the Trustees of the Teamsters Local Union 966 Health Fund.

Utilization Review
A process of evaluating if services, supplies, or treatment are ***medically necessary*** to help ensure cost-effective care.

Union
The ***Union*** is Local Union 966 of the International Brotherhood of Teamsters.

Utilization Review Organization
The individual or organization designated by the ***Trustees*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary.*** The ***Utilization Review Organization*** is MagnaCare.

Well Child Care
Preventive care rendered to eligible ***dependent*** children, as required under the Affordable Care Act.