IBEW LOCAL UNION 400
WELFARE FUND

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

Adopted: May 1, 2016

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ADOPTION

The Trustees of the IBEW Local Union 400 Welfare Fund ***(Trustees)*** have caused this restated IBEW Local Union 400 Welfare Plan ***(Plan)*** to take effect as of the first day of May, 2016, at West Trenton, New Jersey. This is a revision of the Plan previously adopted January 1, 2007. 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 Trustees

Guy Peterson

Michael Tomasiello

Jonathan Viggiano

Edward Wells

Employer Trustees

Thomas O. Johnston, Esq.

Elizabeth Manzo, Esq.

Michael McKiever

DATE: May 1, 2016

GENERAL PLAN INFORMATION

Name of Plan:

IBEW Local Union 400 Welfare Fund

Name, Address and Phone Number of Plan Sponsor:

Trustees of the IBEW Local Union 400 Welfare Fund
830 Bear Tavern Road
PO Box 1028
West Trenton, NJ 08628
Phone: (800) 792-3666

Employer Identification Number:

22-2236617

Plan Number:

501

Type of Plan:

Welfare Benefit Plan: Life insurance, accidental death and dismemberment, medical, dental, prescription drug and vision benefits

Plan Status:

Non-Grandfathered

Essential Health Benefit Benchmark State Plan:

New Jersey

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 ***Plan Administrator*** or ***claims processor.***

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:

I E Shaffer & Co.
830 Bear Tavern Road
PO Box 1028
West Trenton, New Jersey 08628
Phone: (800) 792-3666

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

Name, Address and Phone Number of Claims Processor:

I E Shaffer & Co.
830 Bear Tavern Road
PO Box 1028
West Trenton, New Jersey 08628
Phone: (800) 792-3666

Name, Title, Address and Principal Place of Business for the Trustees:

Union Trustees

Guy Peterson
Business Manager
IBEW Local Union 400
PO Box 1256
Wall, NJ 07719

Jonathan Viggiano
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Michael Tomasiello
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IBEW Local Union 400
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Employer Trustees

Thomas O. Johnston, Esq.
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100 Southgate Parkway
Morristown, NJ 07962

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Brielle, NJ

Elizabeth Manzo, Esq.
Lindabury, McCormick, Estabrook & Cooper, P.C.
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PO Box 2369
Westfield, NJ 07091

Welfare Fund:

This Welfare Fund has been established pursuant to a collective bargaining agreement between Local Union 400 of the International Brotherhood of Electrical Workers, AFL-CIO and the Monmouth-Ocean Division of the Northern New Jersey Chapter, Inc., National Electrical Contractors Association. The Welfare Fund provides benefits for all ***Employees*** covered under the collective bargaining agreement. In addition, certain non-bargaining ***Employees*** of the ***Union*** and the ***Employers*** are also provided benefits by the Welfare 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 ***Plan Administrator.*** The collective bargaining agreement is available for examination in the ***Plan Administrator's*** office.

Reservation of Rights:

Plan benefits for active, retired or disabled 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
Termination of Coverage
Plan Exclusions

Source of Plan Contributions:

Contributions for ***Plan*** expenses are obtained from the ***employers*** and from the covered ***employees*** and their covered ***dependents.*** The ***Trustees,*** working with the ***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.***

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:

March 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 Procedures.*

The designated claims processors are:

I E Shaffer & Co.
Horizon Blue Cross Blue Shield of New Jersey
WellDyneRx
Employee Assistance Program
MetLife Insurance Company

Statement of ERISA Rights:

As a participant in the IBEW Local Union 400 Welfare 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 ***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 ***Plan Administrator,*** copies of documents governing the operation of the ***Plan,*** including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

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

Continued Group Health Plan Coverage

Continued health care coverage 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 the 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 welfare benefit or exercising his or her rights under ERISA.

Enforce the Rights

If a claim for a welfare 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 ***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 ***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 ***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 ***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 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 ***Plan Administrator*** only upon receipt of a certification from the ***Plan Administrato***r that the ***Plan*** documents have been amended to incorporate the following provisions. With respect to PHI, the ***Plan Administrator*** agrees to certain conditions.

The ***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 ***Plan Administrator*** provides PHI received from the ***Plan*** agree to the same restrictions and conditions that apply to the ***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 ***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 ***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
- Reasonable and appropriately safeguard electronic PHI created, received, maintained or transmitted to or by the ***Plan Administrator*** on behalf of the ***Plan.*** Specifically, such safeguarding entails an obligation to:
    - Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that the ***Plan Administrator*** creates, receives, maintains or transmits on behalf of the ***Plan;***
    - 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;
    - 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
    - Report to the ***Plan*** any security incident of which it becomes aware.

SCHEDULE OF BENEFITS

BALANCE-BILLING

In the event that a claim submitted by a ***network*** or ***non-network provider*** is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the ***Plan's*** position that the ***covered person*** should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance-billed for the difference between the billed charges and the amount determined to be payable by the ***Plan Administrator.*** However, balance-billing is legal in many jurisdictions, and the ***Plan*** has no control over non-network providers that engage in balance-billing practices.

In addition, with respect to services rendered by a network provider being paid in accordance with a discounted rate, it is the ***Plan's*** position that the ***covered person*** should not be responsible for the difference between the amount charged by the network provider and the amount determined to be payable by the ***Plan Administrator,*** and should not be balance-billed for such difference. Again, the ***Plan*** has no control over any network provider that engages in balance-billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the ***Plan*** and the network provider.

The ***covered person*** is responsible for payment of ***co-insurances,*** deductibles, and out-of-pocket maximums and may be billed for any or all of these.

CLAIMS AUDIT

In addition to the ***Plan's*** medical record review process, the ***Plan Administrator*** may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the ***Plan Administrator*** has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not ***Usual and Customary*** and/or ***medically necessary*** and ***reasonable,*** if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the ***Plan Administrator*** or its agent to identify the charges deemed in excess of the ***Usual and Customary*** and ***Reasonable*** amounts or other applicable provisions, as outlined in this ***Plan*** document.

Despite the existence of any agreement to the contrary, the ***Plan Administrator*** has the discretionary authority to reduce any charge to a ***Usual and Customary*** and ***Reasonable*** charge, in accord with the terms of this ***Plan*** document.

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, Temporary Disability Benefit, Plan Exclusions* and *Preferred Provider Organization.*

MEDICAL BENEFITS
Tier I

Maximum Benefit Per Covered Person While Covered By This Plan:

Medical	Unlimited

Maximum Benefit Per Covered Person Per Calendar Year For:

Home Health Care	200 visits
Chiropractic Treatment	30 visits per person / 40 visits per family
Skilled Nursing Facility	120 days
Supplemental Speech Therapy	50 visits

Calendar Year Deductible:

Individual Deductible (Per Person)	$0
Family Deductible (Aggregate)	$0
Individual Deductible – Medicare Primary (Per Person)	$0

Co-pays Per Occurrence: (Refer to *Medical Expense Benefit, Co-pay***)**

Emergency Room Visit (waived if admitted)	$100
In-Network Physician Office Visit	$20

Out-of-Pocket Expense Limit Per Calendar Year: (medical expenses only)

Individual (Per Person)	$2,500
Family (Aggregate)	$5,000

The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage (an individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum)

Individual – Medicare Primary (Per Person)	Unlimited
Family – Medicare Primary	Unlimited

Medicare Supplement for Medicare eligible and primary participants:

The ***plan*** pays as a supplement to ***Medicare*** at 100% with no deductible and no out-of-pocket maximum

Refer to *Medical Expense Benefit, Calendar Year Out-of-Pocket 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 until the individual out-of-pocket expense limit has been reached. Thereafter, for the services of ***in-network providers,*** the ***Plan*** pays one hundred percent (100%) of ***incurred covered expenses*** for the remainder of the calendar year. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance.***

Motor Vehicle-Related Injury Exclusion:

Charges for expenses arising due to a motor vehicle-related injury are excluded from coverage. This includes automobiles or other motor or recreational vehicles (e.g. motorcycles, jet skis, all-terrain vehicles, etc.). A ***covered person*** should not advise his or her motor vehicle insurance carrier that he or she has alternate coverage under this ***Plan*** for medical claims arising from an accident. The ***Plan*** will not pay these claims even on a secondary payor basis.

Benefit Description	***In-Network Provider***	***Out-of-Network Provider***
Hospital (in-patient requires pre-certification)	100%	not covered
Outpatient Surgery	100%	not covered
Emergency Room Services	100% after $100 ***co-pay***	100% after $100 ***co-pay***
(***Co-pay*** waived if admitted – charges must be ***incurred*** within 48 hours of ***injury*** or ***illness***)		
Out-of-Network coverage for ***emergency*** services rendered in an ***emergency*** department of a ***hospital*** will be provided on the same basis as ***in-network*** coverage.		
Urgent Care Center	100% after $20 ***co-pay***	not covered
Physician's Services		
Home and Office Visit (including x-rays and lab)	100% after $20 ***co-pay***	not covered
Inpatient Visit	100%	not covered
Surgery	100%	not covered
Anesthesiology	100%	not covered
Diagnostic X-rays & Lab		
Inpatient	100%	not covered
Outpatient	100%	not covered
Out-of-network tests are not covered except for services rendered by ***hospital*** based pathologists and radiologists at ***in-network hospitals.*** In New Jersey, participants must use Laboratory Corporation of America. There is a $20 ***co-pay*** if lab or x-ray is performed in doctor's office.		
Extended Care Facility/Skilled Nursing Facility Limitation: 120 days ***maximum benefit*** per calendar year.	100%	not covered
Home Health Care Limitation: 200 visits ***maximum benefit*** per calendar year, 4 hours = 1 visit.	100%	not covered
Durable Medical Equipment	100%	not covered
Well Child Care & Immunizations	100%	not covered
Routine Physical Examination	100%	not covered
Routine Mammograms	100%	not covered
Preventative Care	100%	not covered
Mental & Nervous Disorders, Chemical Dependency		
Inpatient Services (requires pre-certification) Includes intensive outpatient programs and sub-acute partial hospitalization	100%	not covered
Outpatient Services	100% after $20 ***co-pay***	not covered
Chiropractic Care		
Office Visits Limitation: 30 visits per person or 40 visits per family per calendar year	100% after $20 ***co-pay***	not covered
X-ray & Lab	100% after $20 ***co-pay*** (in office) or 100% (x-ray or lab facility)	not covered
All Other Covered Expenses	100%	not covered

MEDICAL BENEFITS
Tier II

Maximum Benefit Per Covered Person While Covered By This Plan:

Medical	Unlimited

Maximum Benefit Per Covered Person Per Calendar Year For:

Home Health Care	200 visits
Chiropractic Treatment	not covered
Skilled Nursing Facility	120 days
Supplemental Speech Therapy	50 visits

Calendar Year Deductible:

Individual Deductible (Per Person)	$0
Family Deductible (Aggregate)	$0
Individual Deductible – Medicare Primary (Per Person)	$0

Co-pays Per Occurrence: (Refer to *Medical Expense Benefit, Co-pay***)**

Emergency Room Visit (waived if admitted)	$100
In-Network Physician Office Visit	20%

Out-of-Pocket Expense Limit Per Calendar Year: (medical expenses only)

Individual (Per Person)	$2,500
Family (Aggregate)	$5,000

The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage (an individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum)

Individual – Medicare Primary (Per Person)	Unlimited
Family – Medicare Primary	Unlimited

Medicare Supplement for Medicare eligible and primary participants:

The ***plan*** pays as a supplement to ***Medicare*** at 100% with no deductible and no out-of-pocket maximum

Refer to *Medical Expense Benefit, Calendar Year Out-of-Pocket 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 until the individual out-of-pocket expense limit has been reached. Thereafter, for the services of ***in-network providers,*** the ***Plan*** pays one hundred percent (100%) of ***incurred covered expenses*** for the remainder of the calendar year. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance.***

Motor Vehicle-Related Injury Exclusion:

Charges for expenses arising due to a motor vehicle-related injury are excluded from coverage. This includes automobiles or other motor or recreational vehicles (e.g. motorcycles, jet skis, all-terrain vehicles, etc.). A ***covered person*** should not advise his or her motor vehicle insurance carrier that he or she has alternate coverage under this ***Plan*** for medical claims arising from an accident. The ***Plan*** will not pay these claims even on a secondary payor basis.

Benefit Description	***In-Network Provider***	***Out-of-Network Provider***
Hospital (in-patient requires pre-certification)		
Inpatient	100%	not covered
Outpatient	80%	not covered
Outpatient Surgery	80%	not covered
Emergency Room Services	80% after $100 ***co-pay***	80% after $100 ***co-pay***

(***Co-pay*** waived if admitted – charges must be ***incurred*** within 48 hours of ***injury*** or ***illness***)

Out-of-Network coverage for ***emergency*** services rendered in an ***emergency*** department of a ***hospital*** will be provided on the same basis as ***in-network*** coverage.

Urgent Care Center	80%	not covered
Physician's Services		
Home and Office Visit (including x-rays and lab)	80%	not covered
Inpatient Visit	80%	not covered
Surgery	80%	not covered
Anesthesiology	80%	not covered
Diagnostic X-rays & Lab		
Inpatient	100%	not covered
Outpatient	100%	not covered

(Free-standing facility only. Diagnostic x-ray or lab done out-patient at ***hospital*** is covered at 80%).

Out-of-network tests are not covered except for services rendered by ***hospital*** based pathologists and radiologists at ***in-network hospitals.*** In New Jersey, participants must use Laboratory Corporation of America. There is a 20% ***co-pay*** if lab or x-ray is performed in doctor's office.

Extended Care Facility/Skilled Nursing Facility Limitation: 120 days ***maximum benefit*** per calendar year.	100% (in-patient)	not covered
Home Health Care Limitation: 200 visits ***maximum benefit*** per calendar year, 4 hours = 1 visit.	80%	not covered
Durable Medical Equipment	80%	not covered
Well Child Care & Immunizations	100%	not covered
Routine Physical Examination	100%	not covered
Routine Mammograms	100%	not covered
Preventative Care	100%	not covered
Mental & Nervous Disorders, Chemical Dependency		
Inpatient Services (requires pre-certification) Includes intensive outpatient programs and sub-acute partial hospitalization	100%	not covered
Outpatient Services	80%	not covered
Chiropractic Care		
Office Visits	not covered	not covered
X-ray & Lab	not covered	not covered
All Other Covered Expenses	80%	not covered

PRESCRIPTION DRUG PROGRAM
Tier I

MEDICARE *PRIMARY INDIVIDUALS ARE COVERED BY A SEPARATE MEDICARE PART D PLAN. YOU SHOULD REFER TO THE MEDICARE PART D PLAN MATERIALS FOR INFORMATION ON YOUR PRESCRIPTION COVERAGE.*

Out-of-Pocket Expense Limit Per Calendar Year: (prescription drug program expenses only)

Individual (Per Person)	$4,100
Family (Aggregate)	$8,200

The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage (an individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum)

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

Non-***Medicare*** Primary benefits are as follows:

Participating Retail Pharmacy

Prescription Drug Card	100% after ***co-pay***
	Generic: $3 ***co-pay***
	Preferred Brand Name: 20% ***co-pay,*** $150 maximum
	Non-Preferred Brand Name: 50% ***co-pay***

Limitation: 30 day supply

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.*** This penalty is not subject to the maximum ***co-pay*** limitations.

Mail Order

Mail Order Prescriptions	100% after ***co-pay***
	Generic: $6 ***co-pay***
	Preferred Brand Name: 20% ***co-pay,*** $300 maximum
	Non-Preferred Brand Name: 50% ***co-pay***

Limitation: 90 day supply

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.*** This penalty is not subject to the maximum ***co-pay*** limitations.

Specialty Medication

The ***co-pay*** structure for specialty medications is as follows:

20% ***co-pay*** with a maximum of $200 for preferred specialty medications or 20% ***co-pay*** with a maximum of $250 for non-preferred specialty medications. There is an annual ***co-pay*** limit of $2,500.

PRESCRIPTION DRUG PROGRAM
Tier II

MEDICARE *PRIMARY INDIVIDUALS ARE COVERED BY A SEPARATE MEDICARE PART D PLAN. YOU SHOULD REFER TO THE MEDICARE PART D PLAN MATERIALS FOR INFORMATION ON YOUR PRESCRIPTION COVERAGE.*

Out-of-Pocket Expense Limit Per Calendar Year: (prescription drug program expenses only)

Individual (Per Person)	$4,100
Family (Aggregate)	$8,200

The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage (an individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum)

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

Non-***Medicare*** Primary benefits are as follows:

Participating Retail Pharmacy

Prescription Drug Card	100% after ***co-pay***	
	Generic:	$3 ***co-pay***
	Preferred Brand Name:	20% ***co-pay,*** $150 maximum
	Non-Preferred Brand Name:	50% ***co-pay***

Limitation: 30 day supply

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.*** This penalty is not subject to the maximum ***co-pay*** limitations.

Mail Order

Mail Order Prescriptions	100% after ***co-pay***	
	Generic:	$6 ***co-pay***
	Preferred Brand Name:	20% ***co-pay,*** $300 maximum
	Non-Preferred Brand Name:	50% ***co-pay***

Limitation: 90 day supply

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.*** This penalty is not subject to the maximum ***co-pay*** limitations.

Specialty Medication

The ***co-pay*** structure for specialty medications is as follows:

20% ***co-pay*** with a maximum of $200 for preferred specialty medications or 20% ***co-pay*** with a maximum of $250 for non-preferred specialty medications. There is an annual ***co-pay*** limit of $2,500.

DENTAL BENEFITS

STANDARD PLAN:

Calendar Year Deductible:	**$0**
Annual Benefit Maximum Per Covered Person:	
Part A, Part B and Part C per calendar year (including Orthodontics)	$665
Lifetime Orthodontics	**$2,000**
Percentage of Usual and Customary and Reasonable Amount Payable For:	
Part A Dental Services	100%
Part B Dental Services	100%
Part C Dental Services	100%
Orthodontic Services	100%

OPTIONAL DSO PLAN:

Dental Services Organization (DSO) Dental Plan, under which all treatment is provided at Eastern Dental Offices located in New Jersey.

Calendar Year Deductible:	**$0**
Annual ***Maximum Benefit*** Per Covered Family:	Unlimited
Percentage of Usual and Customary and Reasonable Amount Payable For:	
Part A Dental Services	100%
Part B Dental Services	100%
Part C Dental Services	100%
Orthodontic Services	
No patient paid expenses with the exception of a 24 month maximum of:	
Children	$500
Adults	$1,250

VISION BENEFITS

<u>Limitation</u>: Excludes Tier II

Calendar Year Deductible:	**$0**
Annual ***Maximum Benefit*** per ***Covered Person,*** every calendar year	$300
Lifetime LASIK (vision correction surgery) Benefit	**$2,000**

LIFE INSURANCE BENEFITS

Active employees – $10,000 (Life Insurance)

Retired employees – $2,000 (Death Benefit)

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Active employees under age 65 – $10,000

Active employees aged 65 and over and retired employees – $2,000

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:

Horizon Blue Cross Blue Shield at 1-800-664-BLUE (2583)

Emergency hospital admissions are to be reported 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 pre-certified.

There is no benefit payable for ***hospital confinement*** 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.***

IN-NETWORK PROVIDER OR OUT-OF-NETWORK PROVIDER

Covered persons must utilize an ***in-network provider*** in order to receive benefits.

IN-NETWORK PROVIDERS

An ***in-network 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 ***in-network 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 an ***out-of-network provider. Covered persons*** should contact the ***Preferred Provider Organization*** for a current listing of ***in-network providers.***

OUT-OF-NETWORK PROVIDERS

An ***out-of-network provider*** does not have an agreement in effect with the ***Preferred Provider Organization.***

REFERRALS

Referrals to an ***out-of-network provider*** are not covered. It is the responsibility of the ***covered person*** to assure services to be rendered are performed by ***in-network providers*** in order to receive the ***in-network provider*** level of benefits.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by an ***out-of-network provider*** where ***covered expenses*** shall be payable at the ***in-network provider*** level of benefits:

1. ***Out-of-network*** emergency room ***physician*** if the treatment is rendered in a preferred ***facility.***
2. ***Out-of-network*** anesthesiologist if the operating ***facility*** is an ***in-network provider.***
3. Radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by an ***out-of-network provider*** when the ***facility*** rendering such services is an ***in-network provider.***
4. ***Out-of-network*** emergency room ***hospital*** charges for emergency care will be provided on the same basis as ***in-network*** coverage.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The ***Plan Sponsor*** has entered into a contractual agreement with the employee Assistance Program (EAP) whose telephone number is 1-800-527-0035.

The EAP will manage all ***inpatient*** and ***outpatient*** treatment, intensive ***outpatient*** programs and sub-acute partial hospitalization for ***mental and nervous disorders*** or ***chemical dependency.*** In order for the ***covered person*** to receive benefits from the ***Plan*** for ***inpatient*** treatment of ***mental and nervous disorders*** or ***chemical dependency,*** such treatment must be authorized and supervised by the EAP.

There is no benefit payable for ***inpatient*** services for ***mental and nervous disorders*** or ***chemical dependency*** that are not certified.

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 ***Usual and 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.***

CO-PAY

The ***co-pay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment. The service and applicable ***co-pay*** are shown on the *Schedule of Benefits.* The ***co-pay*** must be paid each time a treatment or service is rendered. The ***co-pay*** will not be applied toward the calendar year deductible.

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.*

Family Deductible

If, in any calendar year, covered members of a family incur ***covered expenses*** that are subject to the deductible, equal to or greater than the dollar amount of the family deductible shown on the *Schedule of Benefits,* the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

COINSURANCE

The ***Plan*** pays a percentage of the negotiated rate for ***in-network 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 ***in-network providers.*** For ***out-of-network providers,*** the ***covered person*** is responsible for one hundred percent (100%) of the billed amount. The ***covered person's*** portion of the ***coinsurance*** is included in the out-of-pocket expense limit, along with ***co-pays*** and deductible(s).

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,* the ***Plan*** will begin to pay one hundred percent (100%) for ***covered expenses*** for the services of ***in-network 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 ***Usual and Customary*** and ***Reasonable*** amount, as applicable.

2. Premiums.

3. Balance-billed charges.

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

MAXIMUM BENEFIT

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.***

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 ***Usual and 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 ground ambulance.

Covered expenses shall include:

1. Ambulance services for 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, ***inpatient*** visits, home 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.***

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.

PREGNANCY

Covered expenses for pregnancy or complications of pregnancy shall be provided for a covered female ***employee*** and a covered female spouse of a covered ***employee.*** A ***dependent*** child will receive benefits for routine obstetrical care, but this does not include services provided to the child ***dependent's*** newborn infant.

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*** shall cover services, supplies and treatments for elective abortions or complications from an abortion.

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 considered 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.

PREVENTATIVE CARE

As required by the Patient Protection and Affordable Care Act (PPACA), the Welfare Fund provides 100% coverage for ***in-network/preferred provider*** Preventative Care Services that are not subject to any ***co-payment*** or cost sharing. PPACA defines preventative care services as follows:

Covered Preventive Care Services for Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults – doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection** (STI) prevention counseling for adults at higher risk
- **Syphilis** screening for all adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users

Covered Preventive Care Services for Women, Including Pregnant Women

- **Anemia** screening on a routine basis for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breastfeeding** ***comprehensive support and counseling*** from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Domestic and Interpersonal Violence** screening and counseling for all women
- **Folic Acid** supplements for women who may become pregnant
- **Gestational Diabetes** screening for women 24 to 28 weeks pregnant and those at high risk
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **HIV** screening and counseling for sexually active women
- **Human Papillomavirus (HPV) DNA Test** every 3 years for women with normal cytology results who are 30 or older
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Sexually Transmitted Infection (STI)** ***counseling for sexually active women***

- **Syphilis** screening for all pregnant women or other women at risk
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Urinary Tract** or other infection ***screening for pregnant women***
- **Well-woman Visits** ***to get recommended services for women under 65***

Covered Preventive Care Services for Children

- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
- **Blood Pressure** screening for children
- **Cervical Dysplasia** screening for sexually active females
- **Depression** screening for adolescents
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** ***preventive medication*** for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight** and **Body Mass Index** measurements for children
- **Hematocrit** or **Hemoglobin** screening for children
- **Hemoglobinopathies** or **Sickle Cell** screening for newborns
- **HIV** screening for adolescents at higher risk
- **Hypothyroidism** screening for newborns
- **Immunization** vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis
    - Hæmophilusinfluenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus
    - Inactivated Poliovirus
    - Influenza
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella
- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children

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 physical therapy.

2. 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.*

3. Radiation therapy and chemotherapy.
4. Dialysis therapy or treatment.
5. Home infusion therapy
6. Services of a ***professional provider*** for occupational or respiratory therapy.
7. Cognitive rehabilitation 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 the *Schedule of Benefits.*

HOME HEALTH CARE

Home health care enables the ***covered person*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being ***confined*** in a ***hospital*** or ***extended care facility,*** provided:

1. The ***home health care*** is being provided for the same or related condition for which the patient has been hospitalized for at least three (3) days;
2. The ***home health care*** is being provided in accordance with a ***home health care*** Plan which is established within fourteen (14) days following the beginning of ***home health care.***

Covered expenses shall include:

1. Part-time or intermittent nursing care by or under the supervision of a Registered Nurse. If full-time or twenty-four (24) hour nursing care is required on a short-term basis, such care will be covered for a maximum of three (3) days.
2. Physical, respiratory, occupational or speech therapy.
3. Part-time or intermittent ***home health aide services*** for a ***covered person*** who is receiving covered nursing or therapy services. If full-time or twenty-four (24) hour services are required on a short-term

basis, such care will be covered for a maximum of three (3) days.

4. Medical social service consultations.

5. Nutritional guidance by a registered dietician and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary.***

6. Medical supplies, appliances and equipment.

7. ***Drugs*** and medicines that can be obtained only upon the written prescription of a ***physician.***

8. Laboratory services.

9. Special meals.

10. Diagnostic and therapeutic services, including surgical services, performed in a ***hospital outpatient*** department, a ***physician's*** office or any other licensed health care ***facility,*** but only to the extent that such charges would have been covered had the patient been hospitalized.

A visit by a member of a ***home health care*** team and four (4) hours of home health aide service will each be considered one (1) ***home health care*** visit.

Covered expenses shall be subject to the ***maximum benefit*** specified on the *Schedule of Benefits.*

No ***home health care*** benefits will be provided for:

1. Services or supplies not included in the ***home health care Plan;***

2. Services of an individual who is a member of the patient's family or a member of the patient's spouse's family;

3. ***Custodial care;***

4. Transportation services; or

5. Any period during which the patient is not under the continuing care of a ***physician.***

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 if they are ***medically necessary.***

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 impacted 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.

MENTAL AND NERVOUS DISORDERS

Inpatient

Subject to the pre-certification provisions of the ***Plan,*** the ***Plan*** will pay the applicable ***coinsurance*** for ***confinement*** in a ***hospital*** or ***treatment center*** for services, supplies and treatment related to the treatment of ***mental and nervous disorders.***

Covered expenses shall include:

1. ***Inpatient hospital confinement,*** sub-acute partial hospitalization, and intensive ***outpatient*** programs
2. Individual psychotherapy;
3. Group psychotherapy;
4. Psychological testing;
5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider.***

Outpatient

The ***Plan*** will pay the applicable ***coinsurance,*** up to a ***maximum benefit*** as defined in the *Schedule of Benefits*, for ***outpatient*** services, supplies and treatment related to the treatment of ***mental and nervous disorders.***

CHEMICAL DEPENDENCY

The ***Plan*** will pay for the treatment of ***chemical dependency*** as shown on the *Schedule of Benefits.* Benefits shall be payable for ***inpatient*** or ***outpatient*** treatment in a ***hospital*** or ***treatment center*** by a ***physician*** or ***professional provider.***

ACUPUNCTURE

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

PRIVATE DUTY NURSING

Services of a Registered Nurse for private duty nursing outside of a hospital shall be a ***covered expense***.

CHIROPRACTIC CARE

Covered expense includes initial consultation, x-rays and treatment (but not maintenance care), subject to the ***maximum benefits*** shown on the *Schedule of Benefits.*

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.

ROUTINE PATIENT COSTS FOR PARTICIPATION IN AN APPROVED CLINICAL TRIAL

Covered expenses shall include charges for any ***medically necessary*** services, for which benefits are provided by the ***Plan,*** when a ***covered person*** is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, provided:

1. The clinical trial is approved by:

    a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
    b. The National Institute of Health;
    c. The U.S. Food and Drug Administration;
    d. The U.S. Department of Defense;
    e. The U.S. Department of Veterans Affairs; or
    f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and

2. The research institution conducting the ***Approved Clinical Trial*** and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable ***allowable expense,*** as payment in full for routine patient care provided in connection with the ***Approved Clinical Trial.***

Coverage will not be provided for:

1. The cost of an ***investigational*** new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the ***Approved Clinical Trial;***

2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an ***Approved Clinical Trial;***

3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

4. A cost associated with managing an ***Approved Clinical Trial;***

5. The cost of a health care service that is specifically excluded by the ***Plan;*** or

6. Services that are part of the subject matter of the ***Approved Clinical Trial*** and that are customarily paid for by the research institution conducting the ***Approved Clinical Trial.***

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 services, supplies or treatment related to the treatment of infertility and artificial reproductive procedures, including, but not limited to: Artificial insemination, in-vitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT).

3. 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.

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

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

6. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid.

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

8. Charges for recreational or leisure therapy.

9. 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, exercise equipment.

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

11. Charges for supplies, including smoking deterrent patches, related to the treatment of nicotine addiction..

12. Charges for expenses related to hypnosis.

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

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

15. 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.

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

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

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

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

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, except to the extent required by the Patient Protection and Affordable Care Act.

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).

24. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, 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 sex therapy, diversional therapy or recreational therapy.

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

27. Charges for holistic medicines or providers or naturopathy.

28. Charges for or related to the following types of treatment:

    a. Primal therapy;
    b. Rolfing;
    c. Psychodrama;
    d. Megavitamin therapy;
    e. Visual perceptual training.

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

PRESCRIPTION DRUG PROGRAM

PHARMACY OPTION

Participating pharmacies have contracted with Envision RxOptions 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 *Schedule of Benefits.* The ***co-pay*** amount is not a ***covered expense*** under the *Medical Expense Benefit.*

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) days 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. Allergy medications.

5. Contraceptives.

6. Smoking deterrents.

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. Except as specifically provided, a ***drug*** or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.
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 ***drug*** or medicine which is provided under the *Home Health Care* benefit of this ***Plan.***
10. A charge for prescription ***drugs*** which may be properly received without charge under local, state or federal programs.
11. A charge for hypodermic syringes and/or needles (other than insulin).
13. A charge for infertility medication.
14. A charge for legend vitamins.
15. A charge for any ***drug*** used for cosmetic purposes, including, but not limited to ***drugs*** whose sole purpose is to stimulate or promote hair growth (e.g. Minoxidil).
16. A charge for growth hormones and all analogs, except when medically necessary.
17. 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 Narcoplepsy.

DENTAL EXPENSE BENEFIT

Subject to all the terms of the ***Plan,*** the ***Plan*** will pay a dental benefit for covered dental expenses ***incurred*** by a ***covered person*** who is an ***active employee*** or a ***dependent*** of an ***active employee.*** The dental benefit is a percentage of the ***Usual and Customary*** and ***Reasonable*** amount for ***incurred*** covered dental expenses, as shown on the *Schedule of Benefits.*

DEDUCTIBLE

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 the ***Usual and Customary*** and ***Reasonable*** amount for ***covered expenses.*** That percentage is listed on the *Schedule of Benefits.* The ***covered person*** is responsible for the difference.

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.***

The ***maximum benefit*** for orthodontic treatment while a ***covered person*** is covered by this ***Plan*** is also shown on the *Schedule of Benefits.*

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 installation of a prosthesis, other than a bridge or crown, on the date the impression was made;
2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;
3. For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the ***claims processor*** will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be ***incurred*** as each visit or treatment is completed.

COVERED DENTAL EXPENSES

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

Part A – Diagnostic and Preventive Dental Services

1. Routine oral examination: Initial or periodic, limited to once in any six (6) consecutive month period.
2. Prophylaxis: Scaling and cleaning of teeth, limited to once in any six (6) consecutive month period.

3. Dental x-rays as follows:

    a. Supplementary bite-wing x-rays, limited to once in any six (6) consecutive month period.
    b. Full mouth series limited to one in any thirty-six (36) consecutive month period.

4. Topical application of fluoride.

Part B – Basic and Restorative Dental Services

1. Fillings.

2. Repairing or recementing of crowns, inlays, bridgework or dentures, relining of dentures.

3. Initial installation of partial or full removable dentures (including adjustments for the six (6) month period following installation) to replace one or more natural teeth.

4. Initial complete dentures.

5. Extractions and other oral surgery.

6. Periodontal treatment.

7. Root canal therapy.

8. General anesthesia when ***medically necessary*** and administered in connection with oral surgery or other dental services covered under this ***Plan.***

9. Injection of antibiotic drugs.

10. Space maintainers.

11. Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture or the addition of teeth to an existing partial denture.

Part C – Major Dental Services

1. Gold fillings, inlays or crowns, including precision attachments for dentures.

2. Initial installation of fixed bridgework, including crowns and inlays to form abutments to replace one or more natural teeth which were extracted.

3. Replacement of fixed bridgework by a new fixed bridgework, or the addition of teeth to an existing fixed bridgework.

In addition to all other provisions, limitations and exclusions of this dental benefit, if the denture or bridgework to be replaced was covered under this dental benefit as an initial complete denture or as a replacement, the replacement of such denture or bridgework will be covered only if at least one of the following conditions is met:

1. The dentures or bridgework were installed at least five (5) years prior to replacement; or

2. The existing denture is an immediate temporary denture which cannot be made permanent and replacement by a permanent denture is required and takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

Orthodontic Services

1. Any dental expense furnished in connection with the orthodontic treatment;

2. Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment. Includes routine x-rays, local anesthetics, and post-surgical care.

3. Active appliances. Includes diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

Covered expenses for orthodontic treatment shall be deemed to be ***incurred*** as follows:

1. If the treatment plan allots a single charge to the entire treatment period, and if the treatment period is to last two (2) years or more, one-eighth of the entire charge will be deemed to have been ***incurred*** on the day the first services is provided. One eighth of the charge will be deemed to have been ***incurred*** quarterly thereafter, to a maximum of two (2) years from the date the first charge was ***incurred.***

2. If the treatment plan allots a single charge to the entire treatment period and if the treatment period is to last less than two (2) years, the overall charge will be divided by the number of complete three (3) month time frames in the entire period. This divided charge will be deemed to be ***incurred*** quarterly during the treatment period, with the first such charge to occur on the day the first treatment is provided.

Payments will be made upon the submission of proof that treatments were rendered for the complete quarter.

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. Charges for any denture, bridgework or crown ordered while the individual was covered under this ***Plan*** and not delivered or installed within thirty (30) days after termination of coverage.

2. Replacement of lost, missing or stolen appliances or prosthetic devices.

3. Services, supplies or treatment that is cosmetic in nature (unless required due to accidental ***injury***), including charges for personalization or characterization of dentures. Veneers are considered optional, and as such, are not ***covered expenses.***

4. Charges for services, supplies or treatment paid for or furnished by any employer's medical or dental department, mutual benefit association, labor union or similar organizations, but only to the extend so paid or furnished.

5. A service not furnished by a ***dentist,*** except:
   a. That performed by a licensed dental hygienist under a ***dentist's*** supervision;
   b. X-rays ordered by a ***dentist;*** and
   c. Denturist.

6. Charges for the replacement of existing dentures or bridgework installed less than five (5) years prior to its replacement, unless it is satisfactorily shown that the existing denture or bridgework cannot be made serviceable.

7. Charges resulting from changing from one ***dentist*** to another while receiving treatment, or from receiving care from more than one ***dentist*** for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one ***dentist*** had performed all the required dental services.

8. Charges for instruction in dental plaque control, dental hygienics, or nutritional counseling.

VISION EXPENSE BENEFIT

Vision benefits will be paid for the charges 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.

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 treatment of ***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. Expenses for benefits for any accident or any condition arising out of or in the course of any occupation for wage or profit, or 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 ***Usual and 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 *Third Party Recovery, Subrogation, and Reimbursement.*

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 both the *Medical Expense Benefit* section and the *Dental Expense Benefit* section, and is paid under the *Medical Expense Benefit*, the remaining balance will not be paid under the *Dental Expense Benefit.*

15. Charges for e-mail or telephone consultations, completion of claim forms, 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 ***Plan Administrator*** has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery, felony or criminal act of any nature 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.

19. Charges for care, supplies, treatment, and/or services that do not restore health, unless specifically mentioned otherwise.

20. Charges for care, supplies, treatment, and/or services that are not payable due to the application of any specified deductible provisions contained herein.

21. Charges for care, supplies, treatment, and/or services that are not payable under the ***Plan*** due to application of any ***Plan*** maximum or limit or because the charges are in excess of the ***Usual and Customary*** amount, or are for services not deemed to be ***reasonable*** or ***medically necessary,*** based upon the ***Plan Administrator's*** determination as set forth by and within the terms of this document.

22. Charges for care, supplies, treatment, and/or services that are expenses to the extent paid, or which the ***covered person*** is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government.

23. Charges for care, supplies, treatment, and/or services for expenses actually incurred by other persons.

24. Charges for care, supplies, treatment, and/or services for benefits that are provided, or which would have been provided had the ***covered person*** enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 ***(Medicare)***, including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled *"Coordination of Benefits"* and *"This Plan and Medicare."*

25. Charges for care, supplies, treatment, and/or services that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

26. Charges for care, supplies, treatment, and/or services that are not actually rendered.

27. Charges for care, supplies, treatment, and/or services that are not specifically covered under this ***Plan.***

28. Charges for care, supplies, treatment, and/or services that are to the extent that payment under this ***Plan*** is prohibited by law.

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

All ***employees*** of contributing ***employers,*** whose employment is covered by the Collective Bargaining Agreement by and between IBEW Local Union 400 and the Monmouth-Ocean Division of the Northern New Jersey Chapter, Inc., National Electrical Contractor Association shall be eligible to enroll for coverage under this ***Plan.*** In addition, certain non-bargaining ***employees*** of the ***Union*** and the ***employers*** are also eligible to enroll for coverage under this ***Plan.***

RETIREE ELIGIBILITY

Retired employees may continue coverage under this ***Plan*** provided:

1. The ***retiree*** was eligible for benefits under the Welfare Plan as an ***active employee*** at the time of retirement.

2. The ***retiree*** has attained age 55 or is ***totally and permanently disabled***.

3. The ***retiree*** has earned at least 25 years of Credited Service under the IBEW Local Union 400 Pension Plan (15 years if ***retiree*** is receiving a disability retirement pension benefit), with at least 5 years of Credited Service earned during the 10 plan years immediately preceding their retirement (not applicable to non-bargaining employees).

4. The ***retiree*** will be eligible for Tier I benefits provided he or she has been eligible for Tier I benefits as an ***active employee*** for at least 20 of the 40 quarters immediately preceding their retirement. Otherwise, the ***retiree*** will be eligible for Tier II benefits.

5 The ***retiree*** makes the required monthly contributions in the amount established by the ***Trustees.*** If the ***retiree*** qualifies for Tier I benefits and has not attained age 62, the required contribution is $600 per month. Between age 62 and 64, the required contribution for Tier I benefits is 10% of the ***retiree's*** monthly pension, up to a maximum of $200 per month. After attaining age 65, the required contribution for Tier I benefits is equal to 5% of the ***retiree's*** monthly pension benefit, up to a maximum of $100 per month. If the ***retiree*** fails to make the required contributions at any time, they will not be able to reinstate their eligibility for benefits on a later date.

DEPENDENT(S) ELIGIBILITY

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

1. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage under the laws of the state where the covered ***employee*** lives.

2. The term "child" means the ***employee's*** natural child, stepchild, legally adopted child, foster child or legal ward provided the child has not reached the end of the month in which he or she turns 26 years of age.

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*** elects coverage for himself. An application for enrollment must be submitted

to the ***Trustees*** for coverage under this ***Plan.*** The ***Trustees/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/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/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 18 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 retardation 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 retardation and/or physical disability;
   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

ENROLLMENT

APPLICATION FOR ENROLLMENT

An ***employee*** must file a written application with the ***Plan Administrator*** for coverage hereunder for himself and his eligible ***dependents*** within thirty (30) days of becoming eligible for coverage; and within thirty (30) days of marriage or the acquiring of children or birth of a child. The ***employee*** shall have the responsibility of timely forwarding to the ***Plan Administrator*** all applications for enrollment hereunder.

The ***Trustees/Plan Administrator*** 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 ***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 thirty (30) 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 ***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 thirty (30) days of the acquisition of the ***dependent.***

The ***effective dat***e of coverage as the result of a special enrollment shall be:

1. in the case of marriage, the date of such marriage;

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.***

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.

Employees will become eligible for Tier I benefits on the first day of the month that follows an employment period of not more than 3 consecutive months during which they have been credited with 440 hours of service, provided their employment has been in a category contributing at the "A" rate for journeymen electricians. If their employment has been in a category contributing at less than the "A" rate for journeymen electricians, ***employees*** will be eligible for Tier II benefits. Upon satisfying this requirement, ***employees*** will remain eligible for at least three months.

You Will Become Eligible On:	If You Have 440 Hours During the Prior:
January 1	October through December
February 1	November through January
March 1	December through February
April 1	January through March
May 1	February through April
June 1	March through May
July 1	April through June
August 1	May through July
September 1	June through August
October 1	July through September
November 1	August through October
December 1	September through November

Continued Eligibility and Termination:

To continue their eligibility after satisfying the initial requirement, ***employees*** must have at least 320 hours of service each calendar quarter. An ***employee's*** eligibility will terminate on the last day of the second month following the calendar quarter during which they fail to receive credit for at least 320 hours.

Your Eligibility Will Terminate On:	If You Do Not Have 320 Hours During the Preceding:
February 28	October through December
May 31	January through March
August 31	April through June
November 30	July through September

Upgrade to Tier I Benefits:

As of January 1st of each year, if an ***employee*** is eligible for Tier II benefits, but not for Tier I benefits, they may elect to make additional contributions on their own behalf so as to qualify for Tier I benefits for the remainder of that calendar year. The required additional contribution to qualify for Tier I benefits is currently equal to $19,800 less the ***employer*** contributions actually made on the ***employee's*** behalf for the immediately preceding calendar year. Each year the ***Plan Administrator*** will provide a general notice to each ***employee*** covered under Tier II advising them of their right to upgrade to Tier I. If Tier I coverage is desired, an ***employee*** may request an exact calculation of the amount due and the required additional contribution must be paid within 30 days of being notified by the ***Plan Administrator.***

Downgrade to Tier II Benefits:

If an ***employee*** is covered under Tier I and accepts employment in a category contributing less than the "A" rate for journeymen electricians, their coverage will be reduced to Tier II on the first day of the month following three consecutive months of such employment. Coverage will be restored to Tier I on the first day of the month following three consecutive months of employment in a category contributing at the "A" rate for journeymen electricians.

Reserve Hours:

Hours of service in excess of 400 during a calendar quarter will be placed in a reserve and will accumulate up to a maximum of 1,000 hours. This reserve will be drawn upon to maintain an ***employee's*** eligibility if they should fail to receive credit for at least 320 hours of service during a subsequent calendar quarter, provided an ***employee*** is available for work under a Local 400 Collective Bargaining Agreement requiring contributions to this ***Fund.***

Disability Credit:

After having satisfied the eligibility requirements, if an ***employee*** is ***totally disabled*** and unable to work as an electrician because of ***illness*** or ***injury,*** their eligibility will be continued for as long as they remain ***totally disabled*** but not more than 24 months. To be considered ***totally disabled,*** an ***employee*** must be under the care of a legally qualified ***physician*** and supply proof that they continue to be ***totally disabled*** with such proof required at reasonable intervals by the ***Plan.***

Reinstatement:

Should an ***employee's*** eligibility terminate, it will be reinstated provided they are credited with at least 320 hours of service during a calendar quarter which ends within 10 months after their eligibility terminated. Hours of service worked during the calendar quarter immediately preceding an ***employee's*** termination date, plus any accumulated reserve hours, will be applied towards this 320 hour requirement. An ***employee's*** eligibility will reinstate on the first day of the second month following that calendar quarter during which they meet this 320 hour requirement. If an ***employee*** does not satisfy this reinstatement provision, they will be treated as a new ***employee*** and will be subject to the 440 hour requirement for initial eligibility outlined above.

Non-Bargaining Employees:

If an ***employee*** is a non-bargaining ***employee*** of an eligible participating ***employer,*** they will become eligible on the first day of the fourth month following their employment. An ***employee's*** eligibility will terminate on the last day of the month, which follows the month for which their ***employer*** last makes required contributions.

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 thirty (30) days of meeting the ***Plan's*** eligibility requirements.

1. The date the ***employee's*** coverage becomes effective.
2. The date the ***dependent*** is acquired.
3. 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

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 third month following the a period of two months with no covered employment.

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 may be continued for his surviving covered ***dependents,*** until the earliest of the following:

1. The last day of a period of six months following an ***employee's*** death;
2. The date an ***employee's*** spouse remarries;
3. The date an ***employee's dependent*** becomes eligible for similar benefits under other group coverage;
4. For a covered ***dependent*** child, the date the child attains the maximum eligible age.

Once the 6 month period of initial coverage expires, an ***employee's dependents*** may continue their coverage for an indefinite period of time at the current COBRA rates as described in the following section of this document entitled *"Continuation of Coverage"*. Upon attainment of age 65, the required contribution is $100 per month. For both active and retired ***employees,*** should the surviving spouse remarry, the self-pay privilege ends upon the end of the 36 month period or the date of marriage, if later.

Continuation Under COBRA

If an ***employee*** fails to satisfy the above requirements and loses eligibility, the ***employee*** and their ***dependents*** may continue coverage under COBRA for up to 18 months (29 months if they are ***totally disabled***). If a ***dependent*** loses eligibility due to the ***employee's*** death, divorce or legal separation, or a ***dependent*** ceases to satisfy the definition of an eligible ***dependent,*** they may continue coverage under COBRA for up to 36 months. If an ***employee's*** spouse loses eligibility due to the ***employee's*** death, self-pay continuation of coverage is available for an indefinite period of time at the current COBRA rates. The current monthly rates for the plans under COBRA are:

	Tier I	**Tier II**
Family	$1,350.00	$1,012.50
Parent/Child(ren)	$1,012.50	$ 759.38
Single	$ 675.00	$ 506.25

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/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/ 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/Plan Administrator*** in writing of this choice. The ***Trustees/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/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/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 ***Trustees'*** 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. For purposes of determining monthly costs for continued coverage, a person originally covered as an ***employee*** or as a spouse will pay the rate applicable to an ***employee*** if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an ***employee.***

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. Thirty-six (36) 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. However, if the spouse of a ***retiree*** loses eligibility because of the death of the ***retiree,*** continuation coverage is available for an indefinite period of time, but not beyond the end of the month in which the spouse remarries.

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.

TRADE ADJUSTMENT ASSISTANCE

If a ***covered person's*** coverage under this ***Plan*** terminates due to circumstances which would qualify that ***covered person*** for trade adjustment assistance (TAA) under the terms of the Trade Act of 1974 (19 U.S.C. 2101 et seq.) which covers workers whose employment has been adversely affected by international trade – increased imports or a shift in production to another country, and that ***covered person*** did not elect to continue coverage under the *Continuation of Coverage* provisions of this ***Plan*** during his or her initial sixty (60) day election period as specified herein, a second sixty (60) day election period will be granted. This second sixty (60) day election period shall begin on the first day of the month in which the ***covered person*** is determined to be a TAA-eligible individual. However, the election to continue coverage under this provision of the ***Plan*** cannot be made more than six (6) months after the date of the TAA-related loss of coverage.

If continued coverage is elected under this provision of the ***Plan,*** such coverage shall begin on and any applicable COBRA time frames shall be measured from the first day of the second election period and not on the date of the original qualifying event. All other requirements for continued coverage under the COBRA provisions of this ***Plan*** shall apply.

Any time between the date of the original qualifying event and the first day of the second election period shall NOT count towards any determination of whether the individual has experienced a "break in coverage" (See *Effective Date of Coverage*).

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 ***Plan Administrator/claims processor*** to deal with someone other than them regarding a claim for benefits then the ***covered person*** must provide the ***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 pre-certify 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.

A. 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.

B. 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.

C. 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 ***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 ***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 ***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 ***Plan Administrator*** or its designee, the ***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 ***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 ***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 ***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:

A. Explanation of the denial, including:

1. The specific reasons for the denial;
2. Reference to the ***Plan*** provisions on which the denial is based;
3. A description of any additional material or information necessary and an explanation of why such material or information is necessary;
4. A description of the ***Plan's*** review procedure and applicable time limits;
5. A statement that if the ***covered person's*** appeal (See *"Appealing a Denied 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.

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

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

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

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
2. 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 ***Utilization Review Organization.***

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 one hundred eighty (180) 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:

A. Explanation of the denial including:

1. The specific reasons for the denial
2. Reference to specific ***Plan*** provisions on which the denial is based
3. A statement that the ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits.
4. 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.

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

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

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

1. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
2. 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 at the beginning of the calendar year and 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 two (2) years 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 days 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 ***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:

A. Explanation of the denial, including:

1. The specific reasons for the denial;
2. Reference to the ***Plan*** provisions on which the denial is based
3. A description of any additional material or information necessary and an explanation of why such material or information is necessary
4. A description of the ***Plan's*** review procedure and applicable time limits
5. A statement that if the ***covered person's*** appeal (See *"Appealing a Denied 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.

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

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

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

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

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 one hundred eighty (180) 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 ***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:

A. An explanation of the denial including:

1. The specific reasons for the denial
2. Reference to specific ***Plan*** provisions on which the denial is based
3. A statement that the ***covered person*** has the right to access, free of charge, information relevant to the claim for benefits.
4. 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.

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

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

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

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

VOLUNTARY SECOND LEVEL APPEAL

If the ***covered person's*** first level appeal is denied, he or she may sue for benefits under ERISA. However, before initiating suit, the ***covered person*** may voluntarily elect to submit a second level appeal of any ***pre-service*** or ***post-service claim*** before the Board of Trustees of the Welfare Fund. The ***covered person*** has up to sixty (60) days following receipt of an adverse appeal determination to file a written request for a voluntary second level appeal. Such appeal will be heard by the ***Trustees*** at their next regular quarterly meeting and a decision will be provided to the ***covered person*** within five (5) days thereafter.

The ***Plan*** waives any right to assert that the ***covered person*** has failed to exhaust administrative remedies because the ***covered person*** did not elect to submit a benefit dispute to this voluntary second level of appeal. The ***Plan*** agrees that any statute of limitations or other defense based on timelines is tolled during the time that any voluntary appeal is pending. If this second level appeal is denied, the ***covered person*** may still sue for benefits under ERISA.

The Affordable Care Act ensures the right to appeal health insurance plan decisions. If a ***covered person's Plan*** still denies payment after considering an appeal, the law permits he or she to have an independent review organization decide whether to uphold or overturn the ***Plan's*** decision. This final check is often referred to as an "external review".

When the ***Plan*** denies payment for a treatment or service, a ***covered person*** can request an appeal. When the ***Plan*** receives the request it is required to review its own decision. When the ***Plan*** denies a claim, it is required to notify you of:

1. The reason your claim was denied.
2. The right to file an internal appeal.
3. The right to request an external review if a ***covered person's*** internal appeal was unsuccessful.
4. The availability of a Consumer Assistance Program (when your state has one).

When an internal appeal is requested, the ***Plan*** must give you its decision within:

- 72 hours after receiving the request when it is appealing the denial of a claim for urgent care. (If the appeal concerns urgent care, a ***covered person*** may be able to have the internal and external review take place at the same time.)
- 30 days for denials of non-urgent care a ***covered person*** has not yet received.
- 60 days for denials of services a ***covered person*** has already received.

If after internal appeal the ***Plan*** still denies the request for payment or services, the ***covered person*** can ask for an independent external review.

If the external reviewer overturns the ***Plan's*** decision, the ***Plan*** must give you the payments or services the ***covered person*** requested in the claim.

STATUTE OF LIMITATIONS

In the event an appeal, as described above, is denied by the ***Trustees,*** you have one hundred and eighty (180) days from the date of the written final decision of the denial within which you may file suit in Court against the ***Trustees*** or its authorized representatives disputing such final denial of your claims or benefit appeal. If you do not file suit within the one hundred and eighty (180) days, you are barred and prevented forever from filing suit against the ***Fund,*** the ***Trustees*** or their authorized representatives at any time about the benefit or claim denial. You should also be aware that the ***Trustees,*** the ***Fund*** and the authorized representatives thereof maintain that the Courts of the various states of the United States do not have jurisdiction or authority over such matters, and if you decide to sue the ***Trustees*** or their authorized representative, you must do so in the United States District Court for the District of New Jersey. Any suit commenced in any other Court will not stop the one hundred and eighty (180) day statute of limitation set forth in this provision.

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.

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 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.***

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.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

The ***Plan*** is designed to only pay ***covered expenses*** for which payment is not available from anyone else, including any responsible third party, 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.

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

1. Payment Condition:
    a. The ***Plan,*** in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an ***injury, sickness, disease*** or disability is caused in whole or in part by, or results from the acts or omissions of ***covered persons,*** and/or their ***dependents,*** beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the ***Plan*** may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").
    b. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the ***Plan's*** conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the ***Plan's*** conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the ***Plan*** or the ***Plan's*** assignee. By accepting benefits the Participant(s) agrees the ***Plan*** shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the ***Plan's*** name as a co-payee on any and all settlement drafts.
    c. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the ***Plan*** for all benefits paid or that will be paid by the ***Plan*** on behalf of the Participant(s). If the Participant(s) fails to reimburse the ***Plan*** out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the ***Plan's*** attempt to recover such money.
    d. If there is more than one party responsible for charges paid by the ***Plan,*** or may be responsible for charges paid by the ***Plan,*** the ***Plan*** will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

2. Assignment of Rights (Subrogation): The ***covered person*** automatically assigns to the ***Plan*** any rights the ***covered person*** may have to recover monies in connection with an ***illness, injury,*** accident, ***sickness,*** occurrence, condition or other loss from any third party. These rights of recovery or causes of action against any third party includes, but is not limited to, a claim of any type whatsoever, whether the claim exists or may exist, or the monies are or may be recovered from a third party through a claim, lawsuit, settlement, insurance policy or pool, uninsured or underinsured motorist or other policy or pool, governmental or private right of recovery, Workers Compensation or disability award or order, judgment, no-fault program, or personal injury protection, financial responsibility, medical benefit reimbursement insurance coverage not purchased by the covered person, by compromise, or in any other way from any third party, person, agency, organization or fund of money whether or not the payor caused or is legally responsible or liable for it, and regardless of whether such liability or responsibility is or is not denied or is in dispute (hereinafter called "any third party").

3. Right to Reimbursement, Equitable Lien, and Constructive Trust: The ***Plan*** is granted and the ***covered person*** specifically consents to an equitable lien by agreement, or a constructive trust over, and the ***Plan*** has the right to reimbursement from, any monies that a ***covered person*** receives from or through any third party to the extent of ***Plan*** benefits paid or payable by the ***Plan*** on behalf of the ***covered person.*** The ***Plan's*** right to reimbursement, equitable lien and constructive trust extends to any ***covered person*** who is a participant or beneficiary under the ***Plan,*** including any individuals or entities that may receive a recovery on behalf of a participant or beneficiary, such as the ***covered person's*** spouse, parents, and ***dependents,*** heirs, estates, trusts, representatives, trustees, or guardians of the ***covered person*** including attorneys, representatives, agents, successors or assigns (hereinafter "Covered Individuals").

4. First Priority / Rejection of Make Whole Doctrine: This assignment, right to subrogate, equitable lien by agreement, constructive trust, and right to reimbursement (hereinafter called "Rights of Recovery") applies on a first-dollar basis (i.e. has priority over other rights), applies whether the monies paid to (or for the benefit of) the ***Covered Person*** constitute a full or partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, expert fees, litigation expenses or other costs and expenses. As such, the ***Plan*** is entitled to its full lien and its full recovery of the total amount of benefits paid or payable, regardless of the amount of monies paid or awarded to you by the third party, even if those monies are less than the full amount which you do seek or could seek against the third party, regardless of whether the monies are or are described as for medical expenses, and regardless of how they are described or what they are for, and regardless of whether full compensation from the third party is obtained or available. The ***Plan's*** Rights of Recovery shall be a prior lien against any proceeds recovered by any Covered Individuals, which right shall not be defeated or reduced by the application of any so-called "Make Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the ***Plan's*** recovery rights by allocating the proceeds exclusively to non-medical expenses damages. No reduction of the ***Plan's*** full right to recover the total amount of ***Plan*** benefits is effective without the ***Plan's*** written consent. The ***Plan*** retains the sole and final discretion to decide whether and in what case such consent will be granted, if requested.

5. Rejection of Common Fund Doctrine: The ***Plan's*** Rights of Recovery apply to any recovery by the ***covered person*** without regard to legal fees and expenses (including litigation expenses, expert fees, court costs) of the ***covered person.*** The ***covered person*** shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying ***injury, sickness***, accident, or condition, and the ***Plan's*** recovery shall not be reduced by such legal fees or expenses unless the ***Plan Administrator,*** in his or her sole discretion, agrees in writing to discount the ***Plan's*** claim by an agreed-upon amount of such fees or expenses. The ***Plan*** specifically disavows any claims that a ***covered person*** may make under any federal or state common law defense including, but not limited to, the "Common Fund Doctrine", "Fund Doctrine" or "Attorney's Fund Doctrine."

6. Obligation to Cooperate: The ***covered person,*** as well as the ***covered person's dependent,*** attorney, representative or agent shall assist and cooperate with representatives the ***Plan*** designates, shall do everything necessary to enable the ***Plan*** to enforce its rights of subrogation and reimbursement, and shall do nothing to impair, release, discharge or prejudice the ***Plan's*** Rights of Recovery. The ***Plan Administrator*** may require the ***Covered Person*** to complete and/or execute certain documentation the ***Plan*** deems necessary, helpful or appropriate to assist the ***Plan*** in the enforcement of its subrogation rights including, but not limited to, a Reimbursement and Subrogation Questionnaire, and a Repayment Agreement. Failure to procure such forms will not preclude the ***Plan*** from enforcing its rights under this *Reimbursement and Subrogation* provision.

7. Obligation to Notify: The ***covered person*** shall immediately notify the ***Plan*** if the ***covered person*** is involved in or suffers an ***illness, injury,*** accident, ***sickness,*** occurrence, condition or other loss for which any third party may be liable and shall provide the ***Plan*** with any information concerning the ***covered person's*** other insurance (whether through automobile insurance, other group insurance 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*** as well as the ***covered person's dependent,*** attorney, representative or agent shall again notify the ***Plan*** if the

covered person pursues a claim to recover damages or other relief relating to any ***illness, injury,*** accident, ***sickness,*** occurrence, condition or other loss for which the ***Plan*** may make payments on the ***covered person's*** behalf and shall provide information as to the status of any claim against any third party and such documentation requested by the ***Plan*** every 3 months thereafter, whenever settlement is proposed, and whenever requested by the ***Plan.*** The ***covered person*** shall also notify the third party's attorney of the ***Plan's*** equitable lien, constructive trust, and right to reimbursement. The ***covered person*** as well as the ***covered person's dependent,*** attorney, representative or agent shall immediately notify the ***Plan*** upon receiving any monies, award, judgment, settlement offer or compromise offer, or in any other way from any third party, person, agency, organization or fund of money and shall not settle or compromise any claims without the ***Plan's*** consent. The Participant agrees and shall include the ***Plan's*** name as a co-payee on any and all settlement drafts.

8. Right to Exclude, Withhold or Suspend Covered Expenses: If any ***covered person,*** or the ***covered person's dependent,*** attorney, representative or agent fails or refuses to cooperate with this Third Party Recovery, Subrogation and Reimbursement provision and the Plan's rights by disputing the ***Plan's*** lien, failing to advise the ***Plan*** of the status of the claim against any third party, withholding necessary information, failing to execute requested documentation, or in any way interfering with the ***Plan's*** rights, the ***Plan*** may withhold, suspend and exclude payment of any ***covered expenses*** otherwise available to the ***covered person*** under the ***Plan.*** At the discretion of the ***Plan Administrator,*** the ***Plan*** may withhold or suspend payment of any or all ***covered expenses*** pending reimbursement, pending guaranteed recognition of the ***Plan's*** reimbursement, or pending court order. The ***Plan*** may also reduce any future ***covered expenses*** otherwise available to the ***covered person*** under the ***Plan,*** by an amount up to the total amount of monies recoverable from any third party for ***Plan*** benefits paid or payable by the ***Plan*** on behalf of the ***covered person.***

9. Set Aside of Funds: Unless and until the ***Plan*** has received reimbursement in full, no monies from or through any third party may be distributed to the ***covered person*** without the ***Plan's*** written consent and these monies are, to the extent of benefits paid or payable by the ***Plan*** on behalf of the ***covered person,*** assets of and debts owed to the ***Plan.*** The ***covered person*** agrees to hold in the attorney trust account of the attorney representing the ***covered person,*** the portion of the total recovery from any third party that is due for benefits paid or payable by the ***Plan*** on behalf of the ***covered person.*** The ***covered person*** shall reimburse the ***Plan*** immediately upon receipt of any recovery. The monies held in the attorney trust account shall remain in escrow and shall not be released until the ***Plan*** receives full satisfaction of its lien or right to reimbursement and provides written consent for the release of the monies. Both the ***covered person*** and his or her attorney will be personally liable if the monies subject to the ***Plan's*** lien are not held in an attorney trust account; released without the ***Plan's*** written consent; and/or dissipated on non-traceable items, such as debt obligations.

10. Sole Discretion: The ***Plan*** has sole and final discretion to determine whether to assert its rights under this *Reimbursement and Subrogation* provision as an equitable lien, through subrogation, or through reimbursement, to advance payments of benefits and require repayment, to offset against future payments, or through any combination or variation of these methods. The determination of which method or methods will be used in a particular case will be made to protect the interest of the ***Plan*** and its participants and is in the ***Plan's*** sole discretion.

11. Excess Insurance: If at the time of ***injury, sickness, disease*** or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this ***Plan*** shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the ***Plan's*** *Coordination of Benefits* section.

    The ***Plan's*** benefits shall be excess to:

    a. The responsible party, its insurer, or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

c. Any policy of insurance from any insurance company or guarantor of a third party;
d. Workers' compensation or other liability insurance company; or
e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

12. Separation of Funds: Benefits paid by the ***Plan,*** funds recovered by the Participant(s), and funds held in trust over which the ***Plan*** has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the ***Plan's*** equitable lien, the funds over which the ***Plan*** has a lien, or the ***Plan's*** right to subrogation and reimbursement.

13. Wrongful Death: In the event that the Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the ***Plan's*** subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these ***Plan*** rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

14. Offset: If timely repayment is not made, or the Plan Participant and/or his/her attorney fails to comply with any of the requirements of the ***Plan,*** the ***Plan*** has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Participant's amount owed to the ***Plan.*** To do this, the ***Plan*** may refuse payment of any future medical benefits and any funds or payments due under this ***Plan*** on behalf of the Plan Participant(s) in an amount equivalent to any outstanding amounts owed by the Plan Participant to the ***Plan.***

15. Minor Status:
    a. In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the ***Plan*** to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
    b. If the minor's parents or court-appointed guardian fail to take such action, the ***Plan*** shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

16. Language Interpretation: The ***Plan Administrator*** retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the ***Plan's*** subrogation and reimbursement rights. The ***Plan Administrator*** may amend the ***Plan*** at any time without notice.

17. Severability: In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and ***Plan.*** The section shall be fully severable. The ***Plan*** shall be construed and enforced as if such invalid or illegal sections had never been inserted in the ***Plan.***

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*** and/or ***dependent*** is also enrolled in ***Medicare,*** this ***Plan*** shall pay as the primary Plan. ***Medicare*** will pay as secondary Plan. There are some circumstances under which ***Medicare*** would be required to pay its benefits first. In these cases, benefits under this ***Plan*** would be calculated as secondary payor.

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. For ***retirees,*** this ***Plan*** shall be the secondary payor and ***Medicare*** shall be the primary payor.

6. For ***retirees*** that have other active coverage, you may elect to waive your right to enroll in ***Medicare*** Part B and continue to utilize this ***Plan*** as a secondary payor. Upon termination of the other active coverage, you must elect ***Medicare*** Part B at which time this ***Plan*** will become secondary payor to ***Medicare.*** Failure to elect ***Medicare*** Part B will result in a reduction of benefits under this ***Plan*** to reflect the benefits that would have been available to you had you elected ***Medicare*** Part B coverage.

7. This ***Plan*** shall continue to provide coverage during your ***Medicare*** enrollment process provided you have supplied a copy of your enrollment acknowledgement letter or a copy of your ***Medicare*** card illustrating the effective date of coverage.

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*** shall have full charge of the operation and management of the ***Plan.*** The ***Trustees*** have retained the services of an independent ***Plan Administrator*** and ***claims processors*** experienced in claims review.

The ***Plan Administrator*** is the named fiduciary of the ***Plan*** for all purposes except claim appeals, as specified in *Claim Filing Procedure.* As fiduciary, the ***Plan Administrator*** maintains discretionary authority with respect to those responsibilities for which it has been designated named fiduciary, including, but not limited to, interpretation of the terms of the ***Plan,*** and determining eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan;*** any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

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 has 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).

FRAUD

The following actions by any ***covered person,*** or a ***covered person's*** knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this ***Plan*** for the entire family unit of which the ***covered person*** is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a ***covered person*** of the ***Plan;***
2. Attempting to file a claim for a ***covered person*** for services which were not rendered or drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the ***Plan;*** or
4. Providing any false or misleading information to the ***Plan.***

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.***

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include ***dependents,*** plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the ***Plan*** to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The ***Plan*** may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the ***Plan*** will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the ***Plan*** may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The ***Plan*** will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

INCAPACITY

If, in the opinion of the ***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 ***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 ***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 ***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 ***Plan Administrator*** shall not be liable for any obligation of the ***covered person*** incurred in excess thereof. The ***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 ***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 thereunder 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 ***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 ***Plan Administrator*** or ***employer*** or to interfere with the right of the ***Plan Administrator*** or ***employer*** to terminate the employment of any ***employee*** at any time.

PLAN MODIFICATION AND AMENDMENT

The ***Plan Administrator*** 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 ***Plan Administrator's*** designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***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 ***Plan Administrator.***

PLAN TERMINATION

The ***Plan Administrator*** 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 ***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 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 ***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.

DEFINITIONS

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

Accident

A sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Bodily Injury or Accidental Injury

An ***injury*** sustained as the result of an ***accident*** and independently of all other causes by an outside traumatic event or due to exposure to the elements.

Actively at Work or Active employment

Performance by the ***employee*** of all the regular duties of his or her occupation at an established business location of the participating ***employer,*** or at another location to which he or she may be required to travel to perform the duties of his or her employment. An ***employee*** shall be deemed ***actively at work*** if the ***employee*** is absent from work due to a health factor. In no event will an ***employee*** be considered ***actively at work*** if he or she has effectively terminated employment.

ADA

The American Dental Association.

Adverse Benefit Determination

Any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A recession of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the ***Plan.***

AHA

The American Hospital Association.

Allowable Expenses

The ***Usual and Customary*** charge for any ***medically necessary, reasonable,*** and eligible items of expense, at least a portion of which is covered under a ***Plan.*** When some ***other plan*** pays first in accordance with the Order of Benefit Determinations section herein, this ***Plan's allowable expenses*** shall in no event exceed the ***other plan's allowable expenses.*** When some ***other plan*** provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the ***Plan,*** shall be deemed to be the benefit. Benefits payable under any ***other plan*** include the benefits that would have been payable had claim been duly made therefore.

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.***

AMA

The American Medical Association.

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.***

Approved Clinical Trial

A phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an ***investigational*** new drug application reviewed by the FDA (if such application is required).

Effective January 1, 2014, the Patient Protection and Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the ***Plan*** cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an ***Approved Clinical Trial*** and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the ***Plan*** that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the ***investigational*** item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the ***Plan's*** network area unless ***out-of network*** benefits are otherwise provided under the ***Plan.***

Association

Monmouth-Ocean Division of the Northern New Jersey Chapter, Inc. National Electrical Contractors Association.

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.***

Cardiac Care Unit

A separate, clearly designated service area which is maintained within a ***hospital*** and which meets all the following requirements:

1. It is solely for the treatment of patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the ***hospital;***
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two (2) beds for the accommodation of critically ill patients; and
5. It provides at least one (1) professional registered nurse, who continuously and constantly attends the patient confined in such area on a twenty-four (24) hour a day basis.

Centers of Excellence

Medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The ***Plan Administrator*** shall determine what ***Network Centers of Excellence*** are to be used.

Any ***covered person*** in need of an organ transplant may contact the ***claims processor*** to initiate the pre-certification process resulting in a referral to a ***Center of Excellence.*** The ***claims processor*** acts as the primary liaison with the ***Center of Excellence,*** patient and attending ***Physician*** for all transplant admission taking place at a ***Center of Excellence.***

If a ***covered person*** chooses not to use a ***Center of Excellence,*** the payment for services will be limited to what would have been the cost at the nearest ***Center of Excellence.***

Additional information about this option, as well as a list of ***Centers of Excellence,*** will be given to ***covered employees*** and updated as requested.

Certificate of Coverage

A written certification provided by any source that offers medical care coverage, including the ***Plan,*** for the purpose of confirming the duration and type of an individual's previous coverage.

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.

Child(ren)

For a complete definition of ***child*** refer to Eligibility, Dependent(s) Eligibility.

CHIP

The Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA

The Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

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.

Claim Determination Period

Each calendar year.

Claims Processor

The company contracted by the ***Plan Sponso***r 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.***

Clean Claim

A ***"Clean Claim"*** is one that can be processed in accordance with the terms of this document without obtaining additional information from the service ***professional provider*** or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A ***Clean Claim*** does not include claims under investigation for fraud and abuse or claims under review for ***medical necessity*** and ***reasonableness,*** or fees under review for ***usual and customariness,*** or any other matter that may prevent the charge(s) from being ***covered expenses*** in accordance with the terms of this document.

Filing a ***Clean Claim.*** A ***professional provider*** submits a ***Clean Claim*** by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the ***professional provider*** has knowledge. The ***Plan Administrator*** may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute ***covered expenses*** as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a ***Clean Claim*** if the ***covered person*** has failed to submit required forms or additional information to the ***Plan*** as well.

Close Relative

The ***employee's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***employee's*** spouse.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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 Mental Health Service Providers

Physicians and associated visits which are limited and subject to the benefits and terms of this document. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors licensed to provide individual psychotherapy without supervision in the State they are practicing, may bill the ***Plan*** directly. Other licensed mental health practitioners must be under the direction of and must bill the ***Plan*** through these professionals.

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.

Creditable Coverage

Coverage of an individual under any of the following: A group health plan, health insurance coverage, ***Medicare,*** Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for members and certain former members of the Uniformed Services and their ***dependents,*** a medical care program of the Indian Health Service or a tribal organization, a State health benefits risk pool, a health plan offered under the Federal employees Health Benefits Program, a public health plan, or a health benefit plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children's Health Insurance Program). To the extent that further clarification is needed with respect to the sources of ***Creditable Coverage*** listed in the prior sentence, please see the complete definition of ***Creditable Coverage*** that is set forth in 45 C.F.R. § 146.113(a).

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.

Deductible

The amount of expenses for covered services that a ***covered person*** must pay for him or herself before the ***Plan*** will begin its payments.

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(s) Eligibility.*

Detoxification

The process whereby an alcohol intoxicated person or person experiencing the symptoms of ***substance abuse*** is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with ***drugs*** as determined by a licensed ***physician,*** while keeping the physiological risk to the patient at a minimum.

Diagnosis

The act or process of identifying or determining the nature and cause of a ***disease*** or ***injury*** through evaluation of patient history, examination, and review of laboratory data.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a ***disease*** or condition. It must be ordered by a ***physician*** or other ***professional provider.***

Disease

Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory

to the ***Plan*** is furnished showing that the individual concerned is covered as an ***employee*** under any workers' compensation law, occupational ***disease*** law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the ***Plan,*** be regarded as a ***sickness, illness*** or ***disease.***

Drug

Insulin and prescription legend ***drugs.*** A prescription legend ***drug*** is a Federal legend ***drug*** (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a State restricted ***drug*** (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed ***drug*** dispenser only upon a prescription of a currently licensed ***Physician.***

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 and Emergency Medical Condition

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.

Emergency Services

"Emergency services" shall mean, with respect to an ***emergency medical condition:***

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a ***hospital,*** including ancillary services routinely available to the emergency department to evaluate such ***emergency medical condition;*** and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employee

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

Employer

A member of the ***Association*** and any other ***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.***

ERISA

The employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits

"Essential health benefits" shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; ***emergency services;*** hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription ***drugs;*** rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic ***disease*** management; and pediatric services, including oral and vision care.

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, and that are not the subject of, or in some manner related to, the conduct of an ***Approved Clinical Trial,*** as such term is defined herein.

The ***claims processor,*** Named Fiduciary, ***Plan Administrator*** or their designee must make an independent evaluation of the ***experimental***/non-experimental standings of specific technologies. The ***claims processor,*** Named Fiduciary, ***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, ***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.

Final Internal Adverse Benefit Determination

An ***adverse benefit determination*** that has been upheld by the ***Plan*** at the conclusion of the internal claims and appeals process, or an ***adverse benefit determination*** with respect to which the internal claims and appeals process has been deemed exhausted.

FMLA

The Family and Medical Leave Act of 1993, as amended.

FMLA Leave

A ***Leave of Absence,*** which the Company is required to extend to an ***employee*** under the provisions of the FMLA.

Fund

The ***Fund*** is the IBEW Local Union 400 Welfare 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.

GINA

The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and ***employers*** from discriminating on the basis of genetic information.

Habilitation Services

Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings.

Health Breach Notification Rule

16 CFR Part 318.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended.

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

The continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if ***home health care*** was not provided;
2. The treatment plan covering the ***home health care*** service is established and approved in writing by the attending ***physician;*** and
3. The ***home health care*** is the result of an ***illness*** or ***injury.***

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.

Hospital shall also have the same meaning, where appropriate in context, set forth in the definition of ***Ambulatory Surgical Center.***

Illness

Illness shall have the meaning set forth in the definition of ***Disease.***

Impregnation and Infertility Treatment

Any services, supplies or drugs related to the diagnosis or treatment of infertility.

In-Network 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. ***In-network providers*** agree to accept the ***negotiated rate*** as payment in full.

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.

Late Enrollee

A ***covered person*** who enrolls in the ***Plan*** other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the ***Plan;*** or
2. Through special enrollment.

Leave of Absence

A ***leave of absence*** of an ***employee*** that has been approved by his or her participating ***employer,*** as provided for in the participating ***employer's*** rules, policies, procedures and practices.

Mastectomy

The surgical removal of all or part of a breast.

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,*** or
   c. Visits by a ***home health care agency.***

Medical Child Support Order

Any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a ***covered person's*** child or directs the ***covered person*** to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

Medically Necessary (Medical Necessity)

Service, supply or treatment which, as determined by the ***claims processor,*** Named Fiduciary, ***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;
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, Plan Administrator,*** or its designee, may request and rely upon the opinion of a ***physician*** or ***physicians.*** The determination of the ***claims processor, Plan Administrator*** or its designee shall be final and binding.

Medical Record Review

The process by which the ***Plan,*** based upon a ***medical record review*** and audit, determines that a different treatment or different quantity of a ***drug*** or supply was provided which is not supported in the billing, then the ***Plan Administrator*** may determine the ***maximum allowable charge*** according to the ***medical record review*** and audit results.

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 Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the ***Plan*** (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the ***Plan*** (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

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.

National Medical Support Notice (NMSN)

A notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an ***employee*** who is a ***covered person*** under the ***Plan;***
3. Name and mailing address of one or more ***alternate recipients*** (i.e., the child or children of the ***covered person*** or the name and address of a substituted official or agency that has been substituted for the mailing address of the ***alternate recipients(s)***); and
4. Identity of an underlying child support order.

Negotiated Rate

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

Network

The medical ***provider network*** the ***Plan*** contracts with to access discounted fees for service for ***covered persons.*** The ***network provider*** will be identified on the ***covered person's*** identification card.

No-Fault Auto Insurance

The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

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.***

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.

Other Plan

Shall include, but is not limited to:

1. Any primary payer besides the ***Plan;***
2. Any other group health plan;
3. Any other coverage or policy covering the ***covered person;***
4. Any first party insurance through medical payment coverage, personal ***injury*** protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Workers' compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Out-of-Network 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.

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 Options.

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.

Plan Administrator

The ***Plan Administrator*** is designated by the ***Trustees*** and is responsible for the day-to-day functions and management of the ***Plan.*** The ***Plan Administrator*** is I E Shaffer & Co.

Plan Sponsor

The ***Plan Sponsor*** is the ***Trustees*** of the IBEW Local Union 400 Welfare Fund.

Plan Year

A period commencing on the effective date or any anniversary of the adoption of this ***Plan*** and continuing until the next succeeding anniversary.

Post-service Claim

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

Pre-Admission Tests

Those diagnostic services done prior to a scheduled surgery, provided that:

1. The tests are approved by both the ***hospital*** and the ***Physician;***
2. The tests are performed on an ***outpatient*** basis prior to ***hospital*** admission; and
3. The tests are performed at the ***hospital*** into which ***confinement*** is scheduled, or at a qualified ***facility*** designated by the ***Physician*** who will perform the surgery.

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 Horizon Blue Cross Blue Shield of New Jersey.

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.*

Preventive Care

Preventive Care shall mean certain ***Preventive Care*** services.

This ***Plan*** intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer ***in-Network*** coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the ***Plan*** will provide ***in-Network*** coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here:

http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm

or at *https://www.healthcare.gov/prevention*.

For more information, you may contact the ***Plan Administrator*** at (800) 792-3666.

Prior Plan

The coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the effective date of the ***Plan*** and replaced by the ***Plan.***

Prior to Effective Date or After Termination Date

Dates occurring before a ***covered person*** gains eligibility from the ***Plan,*** or dates occurring after a ***covered person*** loses eligibility from the ***Plan***, as well as charges ***incurred*** prior to the ***effective date*** of coverage under the ***Plan*** or after coverage is terminated, unless extension of benefits applies.

Privacy Standards

The standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

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 Addictions Counselor
- Certified Registered Nurse Anesthetist
- Certified Registered Nurse Practitioner
- Chiropractor
- Clinical Laboratory
- Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
- Dental Hygienist
- ***Dentist***
- Dietician
- Dispensing optician
- Nurse (R.N., L.P.N., L.V.N.)

- Occupational Therapist
- Optician
- Optometrist
- Physical Therapist
- ***Physician***
- Physician's Assistant
- Podiatrist
- Psychologist
- Respiratory Therapist
- Speech Therapist
- ***Psychiatric Hospital***

An institution constituted, licensed, and operated as set forth in the laws that apply to ***hospitals,*** which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a ***Physician;***
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a ***psychiatric hospital;***
4. It requires that every patient be under the care of a ***Physician;*** and
5. It provides twenty-four (24) hour a day nursing service.

The term ***psychiatric hospital*** does not include an institution, or that part of an institution, used mainly for nursing care, rest care, convalescent care, care of the aged, ***custodial care*** or educational care.

Qualified Medical Child Support Order (QMCSO)

A Medical Child Support Order that creates or recognizes the existence of an ***alternate recipient's*** right to, or assigns to an ***alternate recipient*** the right to, receive benefits for which a ***covered person*** or eligible ***dependent*** is entitled under this ***Plan.***

Reasonable

Reasonable and/or ***Reasonableness*** shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of ***illness*** or ***injury*** not caused by the treating ***provider.*** Determination that fee(s) or services are ***reasonable*** will be made by the ***Plan Administrator,*** taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of ***injury*** or ***illness*** necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be ***reasonable,*** service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not ***reasonable.*** The ***Plan Administrator*** retains discretionary authority to determine whether service(s) and/or fee(s) are reasonable based upon information presented to the ***Plan Administrator.*** A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not ***reasonable.***

Charge(s) and/or services are not considered to be ***reasonable,*** and as such are not eligible for payment (exceed the ***maximum allowable charge***), when they result from ***provider*** error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The ***Plan*** reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the ***Plan,*** to identify charge(s) and/or service(s) that are not ***Reasonable*** and therefore not eligible for payment by the ***Plan.***

Rehabilitation Hospital

An ***institution*** which mainly provides therapeutic and restorative services to sick or ***injured*** people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State and local laws;
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities; or
3. It is approved for its stated purpose by ***Medicare.***

Retiree

A former ***employee*** who retired from service of the ***employer*** and has met the ***Plan's*** eligibility requirements to continue coverage under the ***Plan*** as a ***retiree.*** As used in this document, the term ***employee*** shall include ***retirees*** covered under the ***Plan*** unless otherwise specified.

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.

Scheduled Benefit or Scheduled Benefit Amount

A specified dollar amount that will be considered for reimbursement under the ***Plan*** for a particular type of medical care, service or supply provided. ***Scheduled benefits*** are based upon ***covered expenses*** not otherwise limited or excluded under the terms of the ***Plan.*** A partial listing of ***scheduled benefit amounts*** may be found in the section, *"Schedule of Benefits"*.

Scheduled benefit amounts are determined taking into consideration (but not restricted to) the lesser of the ***Usual and Customary*** fee for services and/or supplies, which are deemed to be both ***reasonable*** and ***medically necessary***, and:

1. For ***inpatient hospital*** expenses, the ***Medicare*** Diagnosis Related Group ("DRG") scheduled dollar conversion amounts based upon the CMS weighted values;
2. For ***outpatient hospital*** expenses, the CMS Ambulatory Payment Classification (APC) based upon the CMS weighted values;
3. For ***Physicians*** and other eligible ***providers, scheduled benefit amounts,*** the lesser of the ***scheduled benefit amount*** or one hundred and twenty-five percent (125%) of the CMS Reimbursement Schedule for the CMS area;
4. For ***ambulatory surgical centers*** (ASC) the lesser of the ***scheduled benefit amount*** or one hundred and twenty-five percent (125%) of the CMS Reimbursement Schedule for the CMS area;
5. At the ***Plan Administrator's*** discretion, ***Medicare*** cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices; and
6. If the ***Plan Administrator*** is unable to determine ***scheduled benefit amounts*** utilizing the aforementioned process, it shall, at its sole discretion, determine ***scheduled benefit amounts*** considering accepted industry-standard documentation uniformly applied without discrimination to any ***covered person.***

Security Standards

The final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

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.

Service Waiting Period

An interval of time during which the ***employee*** is in the continuous, active employment of his or her participating ***employer.***

Sickness

Sickness shall have the meaning set forth in the definition of ***disease.***

Significant Break in Coverage

A period of sixty-three (63) consecutive days during each of which an individual does not have any ***creditable coverage.***

Substance Abuse

Any use of alcohol, any ***drug*** (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a ***drug.*** The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:
    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
    b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
    c. Craving or a strong desire or urge to use a substance; or
    d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);
2. The symptoms have never met the criteria for substance dependence for this class of substance.

Surgery

Any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

Surgical Procedure

Surgical procedure shall have the same meaning set forth in the definition of ***surgery.***

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 IBEW Local Union 400 Welfare Fund.

Uniformed Services

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

Union

The ***Union*** is the Local Union 400 of the International Brotherhood of Electrical Workers.

USERRA

The Uniformed Services employment and Reemployment Rights Act of 1994 ("USERRA").

Usual and Customary

Covered expenses which are identified by the ***Plan Administrator,*** taking into consideration the fee(s) which the ***provider*** most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the ***provider*** for providing the services, the prevailing range of fees charged in the same "area" by ***providers*** of similar training and experience for the service or supply, and the ***Medicare*** reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of ***providers,*** persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be ***usual and customary,*** fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was ***Incurred.***

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term ***"usual and customary"*** does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a ***covered person*** by a ***provider*** of services or supplies, such as a ***Physician,*** therapist, Nurse, ***hospital,*** or pharmacist. The ***Plan Administrator*** will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the ***Plan Administrator's*** discretion, alternatively be determined and established by the ***Plan*** using normative data such as, but not limited to, ***Medicare*** cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Utilization Review

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

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.***