SUMMARY PLAN DESCRIPTION

of the

Plan of Benefits

of the

TEAMSTERS HEALTH
AND WELFARE FUND
OF PHILADELPHIA AND VICINITY

Top Plan
(PPO)

March 2013

This Summary Plan Description ("SPD" or "Booklet") constitutes the Fund's Plan document. This Booklet contains the Fund's complete Health and Welfare Benefit program as of the date of publication. The only benefits to which you are entitled are those stated in this booklet, and are determined by the rate of contribution as defined in the Collective Bargaining Agreement between your Employer and Union. For those Members enrolled in the PPO Plan, your hospital and medical/ surgical benefits are those set forth in the Horizon Blue Cross/Blue Shield of New Jersey Member Handbook which is incorporated into this document. From time to time, the Fund's Trustees may amend your Plan, the details of which are set forth in this Booklet. Should that occur, the Fund routinely advises you of such changes in the Fund's newsletter or by way of special bulletins.

The only person authorized to advise you of your rights under this Plan is the Fund Administrator, William J. Einhorn, or his specific designee.

Reliance upon information from any other source is at your own risk.

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Reach us on the Web at www.teamsterfunds.com

Among other employees, the Health & Welfare Fund covers
employees represented by these Teamsters Locals

Local 107	Local 115	Local 312	Local 326	Local 331	Local 384
Local 463	Local 500	Local 623	Local 628	Local 676	Local 929

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Dear Participants: March 2013

Several years have passed since our last SPD was published. In the intervening years, many amendments to the Fund's plan of benefits and new types of benefit programs have been adopted by your Board of Trustees, including several mandated by the Patient Protection Affordable Care Act (the Affordable Care Act). This updated SPD incorporates those changes, as well as others, into a single source for your reference.

The "Dual Option" medical program, the Dental PPO, Vision PPO, Behavioral Health and Disease Management Programs have served as models upon which other benefit plans have relied and copied. The Fund's service agreements with Horizon Blue Cross and Aetna provide members with a permanent identification card, good anywhere in the country and at the same time, have streamlined hospital claim processing with significant savings to the Fund.

You can help conserve your valuable benefits by:

- Discussing fees with your physician. He or she estimates what he or she thinks you can pay. If you do not act concerned, he or she may overestimate.
- Requesting outpatient hospital care whenever possible.
- Questioning what appears to be unnecessary hospital treatment or charges as you would if you were paying the bill. Remember, your medical coverage has a annual limit!
- Requesting that your physician not keep you in the hospital for any longer than necessary.
- Following your physician's advice regarding steps to take care of your medical condition.
- Taking advantage of the services offered through the Fund's Disease Management program.

Take the time to read the material in this booklet. These are valuable benefits that are of critical importance to you and your family. Every effort has been made to describe your benefit coverage in easy-to-understand language. Nevertheless, health coverage is a complicated item that oftentimes does not lend itself to easily described terms and concepts. For that reason, the Fund maintains a Member Services Department staffed with highly trained personnel, well versed in the Fund's plans, and ready to assist you in answering your questions and benefit inquiries.

We hope you will agree that these are valuable benefits to be used wisely. Get the most value for each of your Fund dollars by being an *aware, informed and concerned* health benefits consumer.

Sincerely,

THE BOARD OF TRUSTEES

William Hamilton, Jr., Local 107 (Union Co-Chairman)
Howard Wells, Local 676
Robert "Rocky" Bryan, Jr., Local 929

Kenneth F. Leedy (Employer Co-Chairman)
Bob Schaeffer, Jr., Transport Employers Assoc.
Tom J. Ventura, YRC Worldwide, Inc.

WHAT TYPES OF BENEFITS ARE OFFERED THROUGH THE FUND?

The Teamsters Health and Welfare Fund of Philadelphia and Vicinity provides the following types of benefits to eligible Members and their dependent beneficiaries:

1. Medical benefits
2. Prescription drug coverage;
3. Behavioral health and substance abuse treatment;
4. Dental benefits;
5. Short terms disability benefits;
6. Vision benefits; and
7. Life insurance and accidental death and dismemberment benefits.

All of the benefits provided through the Fund are subject to certain eligibility provisions and exclusions, which are set forth in more detail in this Summary Plan Description, which also serves as the Fund's Plan Document.

HOW ELIGIBILITY TO PARTICIPATE IN THE FUND WORKS

I. WHEN DOES A FUND MEMBER BECOME ELIGIBLE TO PARTICIPATE IN THE FUND?

There are two ways a Fund Member becomes eligible to receive Fund benefits, both of which depend upon the terms of the Member's Collective Bargaining Agreement with his or her Employer. If your[1] Employer is required to make contributions to the Fund on your behalf in the form of a *monthly premium* (instead of a stated amount per hour or day), then you will be eligible for benefits during the month in which the premium is due to be paid by your Employer. This is called "same month eligibility."

If, on the other hand, your Employer makes contributions to the Fund based on an hourly or daily rate, then you are subject to the Fund's "regular eligibility" provisions. The following qualifying schedule illustrates how regular eligibility works:

If your Employer makes contributions to the Fund on your behalf for at least 15 days during the month of :	Or, if your Employer makes contributions on your behalf for 180 days during the months of:	Then you will be eligible for Fund benefits during the month of:
November	December through November	January
December	January through December	February
January	February though January	March
February	March through February	April
March	April through March	May
April	May through April	June
May	June through May	July
June	July through June	August
July	August through July	September
August	September through August	October
September	October through September	November
October	November through October	December

II. WHICH TYPES OF DEPENDENTS ARE COVERED BENEFICIARIES UNDER THE FUND, AND WHEN DO THEY BECOME ELIGIBLE FOR FUND BENEFITS?

Certain members of your family qualify as Dependent beneficiaries under the terms of the Fund. They are as follows:

A. Your Spouse (as defined herein), as long as you are not separated, which means you are living separate and apart (even under the same roof) with an intent to abandon or terminate the marital relationship.

B. Your dependent children, which include your natural or adopted, adult, non-handicapped children who have not reached the age of twenty-six (26), whether married or unmarried, provided through December 31, 2013, said adult children are not eligible for other employer-sponsored health plans coverage (other than through the Plan covering your spouse).

C. Your wholly dependent, unmarried children who are physically or mentally incapable of self-support upon attaining age twenty-six (26) will continue to be covered PROVIDED you furnish the Fund office with proof of this incapacity BEFORE their coverage terminates at age twenty-six (26). You should request the appropriate form from the Fund office. Thereafter, yearly certifications are required to verify the continuing nature of the dependent's handicapped status.

D. Your wholly dependent parents, provided that you are unmarried and have no other dependents and such parents are living in your household. The Fund's coverage will be secondary for parents who are eligible to apply for benefits under any medical assistance program for the aged provided by a State or the Federal Government.

[1] The words "you" and "your" in this SPD refer to Fund Members, generally, and in some cases their Dependent beneficiaries.

There are a few exceptions to these general rules, which are important to note. First, any individual who is a full-time Member of the Armed Forces or who is eligible for coverage as an Employee under this plan is not eligible to be a Dependent under this Fund. Second, when both a husband and wife are covered by the Fund as eligible Members, Fund deductibles, coinsurance, and co-payments will not be taken. Beyond that, payment will be determined based upon Fund allowances (UCR, etc.) and under Coordination of Benefits (see General Provisions and Definitions section).

A SPECIAL NOTE FOR "SINGLE" EMPLOYEES:

Some collective bargaining agreements provide for "employee only" health and welfare benefit coverage, which the Fund refers to as "Single" employee status. If you are or become a "Single" employee, as determined by the Fund, the benefits described in this booklet are limited to you, the employee. Contact the Fund if you are unsure as to your status as a "Family" or "Single" employee. NO COVERAGE IS PROVIDED FOR THE SPOUSE OR DEPENDENT CHILDREN OF A "SINGLE" EMPLOYEE.

III. HOW DOES A MEMBER OR DEPENDENT BENEFICIARY LOSE HIS OR HER ELIGIBILITY FOR FUND BENEFITS?

There are circumstances when a Fund Member or his or her Dependent beneficiary may lose their eligibility for Fund benefits. Those circumstances are described below:

A. Loss of Participant Eligibility

Your eligibility automatically terminates if any of the following events take place:

1. When you have less than the required number of contribution days to your credit in accordance with the qualifying schedule for regular eligibility on page 2 and do not qualify for the Extension of Benefits Provisions on page 5; or

2. When you cease to be a Member of a class of employees covered by your Employer's Collective Bargaining Agreement with a participating Local Union, or otherwise no longer qualify as a Member as defined herein, (except if you leave Covered Employment prior to retirement, you may continue to exhaust earned eligibility credits for a period not to exceed two (2) months); or

3. When you become self-employed outside the scope of a Collective Bargaining Agreement; or

4. When the benefit program is terminated; or

5. Immediately upon the date on which any Participating Local Union and Contributing Employer(s) agree that the then Contributing Employer(s) shall no longer make contributions to the Fund on your behalf.

NOTE: YOUR EMPLOYER'S ACTIONS ALSO AFFECT YOUR ELIGIBILITY!

A Member's eligibility and his or her dependents' eligibility will be suspended automatically if his or her Employer becomes more than two (2) months delinquent in remitting contractually required contributions to the Fund. Eligibility for Fund benefits will be reinstated if and when the Member's Employer remits all delinquent contributions to the Fund, provided that the Member is otherwise eligible for such benefits.

Also, if your collective bargaining agreement expires and it is not promptly replaced by an interim agreement or new collective bargaining agreement, the Fund has no choice but to suspend your benefits until a new agreement is put into place.

No matter what else might be written in this Booklet, a Member will not be eligible for benefits incurred during any Benefit period in which:

A. His or her Employer is not a Contributing Employer, or

B. His or her Employer is making contributions or payments of any kind to any party (other than this Fund) for the purpose of providing Health and Welfare benefits to the Member which duplicate in any way the benefits provided under this Fund.

B. Loss of Dependent Eligibility

A Dependent beneficiary's eligibility for Fund benefits will automatically terminate if any of the following events take place:

1. When the Member's eligibility terminates; or
2. When a dependent enters full-time military, naval or air service; or
3. When a dependent ceases to be a "dependent" as defined herein; or
4. In the case of children:
   a. When a Member's child(ren) attain the age of 26 years, except children who are physically or mentally incapable of self-support; or
   b. When a dependent child becomes eligible as an employee under a group health plan sponsored by any employer.

NOTE: IF YOUR FAMILY STATUS CHANGES

It is important that you give prompt, written, notice to the Fund office on a Census Card of any change in your Family Members, such as marriage, birth of a child, death of your spouse, divorce, or separation as these events are what is known as a "change in status." (Furthermore, a description of the procedures governing qualified medical child support order determinations can be obtained, without charge, from the Fund office.) The failure to report any change in your Family Members may result in a delay of payment of a claim at a future date or may adversely affect your COBRA right to continuation coverage, which is described below.

Census Cards are always available at the Fund office or on the Fund's web site, www.teamsterfunds.com. In certain situations you may be required to submit a certified copy of your most recent federal income tax return and other necessary documents in order to establish proof of dependency for a particular Family Member when a change in status occurs. Similarly, it is most important that you immediately notify the Fund of any change in your address.

IV. THERE ARE WAYS TO CONTINUE RECEIVING FUND BENEFITS AFTER OTHERWISE BECOMING INELIGIBLE FOR THEM

There are three separate ways a Fund Member and Dependent beneficiary may continue to receive Fund benefits after he or she becomes ineligible for them. One such method is a result of the Fund's design, while the others are required under federal law.

A. The Fund's Extension of Benefits Provisions

Should a Member lose eligibility because he or she has less than the required number of contribution days to his or her credit as set forth in the qualifying schedule of eligibility, then MEDICAL or DENTAL expenses incurred after the Member or Dependent is no longer eligible for Fund benefits will be considered covered expenses related to a previous eligible claim and payable under this Plan provided the following conditions are satisfied:

1. The current actual charges are related to a diagnosis which was initially treated while the patient was eligible for benefits, and

2. The current actual charges were incurred within ninety (90) days of the initial treatment (that is, first date of service by a medical service provider) of the related injury or disease.

B. COBRA Continuation Coverage

In some cases, should you and/or your dependents become ineligible for coverage under the Fund's Plan of Benefits, you have certain rights, under certain conditions, to continue your coverage under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

Under this law, there are circumstances under which you can receive a temporary extension of your health care coverage at group rates. This extension applies to you and your dependents if you and they were covered by the Fund on the day before your or their coverage ended. COBRA refers to these people as "Qualified Beneficiaries."

A Qualified Beneficiary need not show evidence of good health in order to continue coverage. However, the Qualified Beneficiary is obligated to pay a set amount as a premium for this continuation of coverage. The premium that must be paid may be different than the contribution rate being paid by your Employer. The COBRA premium rates are formulated by the Fund's Actuary in accordance with formulas defined in the federal COBRA law. Pro rated credits are given in those cases where the Employer has made some contributions on your behalf, but not enough for you to qualify for normal eligibility.

You have the right to extend your coverage if the coverage ends because:

1. You leave employment with an Employer for reasons other than gross misconduct on your part; or
2. You no longer meet the eligibility requirements.

Your spouse has the right to extend coverage if:

1. You die;
2. You leave employment as described above, or no longer meet the eligibility requirements;
3. You are divorced or separated; or
4. You become eligible for Medicare.

Your dependent children have the right to this extended coverage if:

1. You die;
2. You leave employment as described above, or no longer meet the eligibility requirements;
3. You are divorced or separated (step-children only);
4. You become eligible for Medicare; or
5. They are no longer considered dependents under the provisions of the Fund's Plan of Benefits.

It is the responsibility of the person who will lose coverage to inform the Administrator of a divorce, separation or a loss of dependent child status. The Administrator must be notified, in writing, within sixty (60) days after one of these events occur. If the Administrator is not notified, then that person will not be able to elect to continue his or her other coverage.

Once the Administrator is notified of an event that affects the coverage of a Qualified Beneficiary, the Qualified Beneficiary will be notified that he or she has the right to choose continuation coverage. He or she then has at least sixty (60) days from the date he or she would lose coverage to let the Administrator know that he or she wants to continue coverage. If the Qualified Beneficiary did not choose it, the right to continue the group health coverage would then end. If he or she does choose it, he or she will be offered the right to continue the same coverage he or she was receiving the day before he or she lost coverage, except for the Death Benefit, Accidental Death and Dismemberment Benefit and Weekly Disability Income Benefits. Each Qualified Beneficiary can make a separate choice on whether to continue coverage. However, one person can make an effective choice to continue coverage for everybody. You can choose to continue only your core benefits - hospital, medical, surgical and prescription drug benefits - or these benefits plus your non-core benefits - vision and dental benefits.

1. Certificate of Former Coverage

If you or your dependents lose coverage under the Plan, you will receive a certificate of former coverage. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage stops. You may request another copy of the certificate within 24 months of losing coverage.

If coverage ended because you left employment, or no longer meet the eligibility requirements, coverage may continue for up to eighteen (18) months. If coverage ended for any other reason, then coverage may be continued for up to thirty-six (36) months. These time periods may be shortened if:

a. The Fund no longer provides group health coverage for any employee;
b. You do not pay the required premium in a timely fashion;
c. You are later employed and are covered by another group health plan that does not contain any exclusion or limitation with respect to a pre-existing medical condition that is applied by the plan;
d. You become eligible for Medicare; or
e. You are divorced, subsequently remarry and are covered under your new spouse's group health plan.

2. Special Rule for Multiple Qualifying Events

If you elect continuation coverage following a termination of employment or reduction in hours and, during the 18 month period of continuation coverage, a second event (other than a bankruptcy proceeding) occurs that would have caused you to lose coverage under the Plan (if you had not lost coverage already), you may be given the opportunity to extend the period of continuation coverage to a total of 36 months. If you elected continuation coverage as the spouse or dependent of a covered employee who experienced a termination of employment or reduction in hours and, during the continuation period the employee or former employee becomes entitled to Medicare, you may be given the opportunity to extend coverage for 36 months from your initial qualifying event.

3. Special Rule for Medicare Recipients

If your Spouse was eligible for or receiving Medicare prior to your qualifying event, then your Spouse may continue his or her coverage under COBRA for up to 36 months. Your continuation coverage, however, may not exceed 18 months in such a situation. If you and your Spouse were not eligible for Medicare prior to your qualifying event, and you become eligible for Medicare during your COBRA continuation period, your continuation coverage will terminate but your Spouse will be able to continue his or her coverage for 18 months or until your Spouse becomes eligible for Medicare, whichever is sooner.

4. Special Rule for Totally Disabled Qualified Beneficiaries

The 18-month period of continuation coverage may be extended for an additional 11 months (up to a total of 29 months), for any individual who is determined to have been disabled (for Social Security purposes) at the time your work hours were reduced, or your employment ended, or any time during the first sixty (60) days of the 18 month period during which you are enrolled in the

COBRA program. To qualify for this additional coverage, the individual must provide the Plan with notice, within sixty (60) days of the date of the determination and before the end of the 18-month coverage period, of Social Security's disability determination, and must remain disabled throughout the additional coverage period. The premium cost for COBRA continuation during the additional coverage period will be approximately 50 percent higher.

If you have any questions about this continuation coverage, please contact the Fund office.

C. Continuation Rights Related to Military Service

If you are a Member of any of the United States Uniformed Services (i.e., Army, Navy, Air Force, Marines, Coast Guard, and Public Health Service), and you are deployed on active duty, you have certain rights to continue or suspend your health and welfare benefits under the Fund's plan of benefits. Those rights are governed under the Uniformed Services Employment and Reemployment Rights Act, which is commonly referred to as "USERRA." Because the Fund is a multiemployer plan, your USERRA continuation rights differ slightly from those provided under a single employer plan. Generally speaking, and assuming your Employer is not required to make contributions on your behalf during your deployment, you have three (3) separate options regarding your health and welfare benefits during a period of active duty with one of the Uniformed Services. ***REGARDLESS OF WHICH OPTION YOU CHOOSE TO ELECT, IT IS CRITICALLY IMPORTANT THAT YOU AND YOUR EMPLOYER CONTACT THE FUND OFFICE TO NOTIFY US OF YOUR DEPLOYMENT AND THAT YOU DISCUSS YOUR CONTINUATION OPTIONS WITH ONE OF THE FUND'S MEMBER SERVICE REPRESENTATIVES.***

Your first option, which also happens to be the Fund's default option, is that you may suspend your eligibility beginning with the first full month following your deployment date. Under this option, you and your dependent beneficiaries will have your eligibility for Fund benefits suspended during your period of service. Upon your return from active duty, your benefits will be reinstated at no cost to you provided that you have sufficient banked eligibility from the period of time preceding your active duty to be eligible for Fund benefits. If you do not have sufficient banked eligibility, you will still be eligible for immediate reinstatement in the Fund, but you will be required to pay for your coverage until you have sufficient work history to be eligible for Fund benefits.

Your second option is to run out your eligibility using the Fund's twelve month look back described on page 2 during your deployment and to suspend your eligibility thereafter. Under this option, your eligibility will continue until such time as you do not have sufficient work history in the preceding twelve months to confer eligibility for fund benefits on you. Once your eligibility runs out, your benefits will be suspended unless you pay for continuation coverage. When you return from active duty, you will still be eligible for immediate reinstatement in the Fund, but you will be required to pay for your coverage until you have sufficient work history to be eligible for Fund benefits. If you do not notify the Fund of your deployment and you or your dependents use your health benefits while deployed, you will be deemed to have elected this option.

Your third option is to save your banked eligibility during the period of active duty, but to continue your health and welfare benefits during your deployment by paying for them. Once you return from active duty, you can cease to pay for your benefits by using your banked eligibility provided you have sufficient banked eligibility from the period of time preceding your active duty to be eligible for Fund benefits. If you do not have sufficient banked eligibility, you will still be eligible, but you will be required to pay for your coverage until you have sufficient work history to be eligible for Fund benefits.

ATTENTION!

Each of the above options assumes your Employer is not required under your collective bargaining agreement to make health and welfare contributions to the Fund on your behalf during your deployment. If your collective bargaining agreement requires your Employer to make Health and Welfare contributions on your behalf during your deployment, you should contact the Fund office to discuss how those contributions will affect your eligibility during your period of active duty.

THE FUND'S MEDICAL PROGRAM AND HOW IT WORKS

If you have received a copy of this document, then you have elected to participate in the Fund's PPO program for medical benefits. The Fund's PPO program requires you to make a larger financial investment in your health care than the Fund's HMO program, but offers you more flexibility in selecting your health care providers by, for example, eliminating the need to obtain a referral before seeing a specialist.

Both of the Fund's medical programs are self-insured, which means that Fund medical benefits are paid out of a trust fund that is funded through the contributions of all of the Fund's participating employers for the benefit of the Fund's Members and beneficiaries subject to the terms and conditions of this SPD. As a result, the Fund's medical program has been designed to offer a cost-effective, but comprehensive plan of benefits that keeps its Members and beneficiaries healthy through disease management and providing access to a broad network of medical providers and facilities.

The Fund's PPO program participates in the Horizon Blue Cross/Blue Shield Blue Card PPO program. This means that any Blue Cross/Blue Shield participating medical provider in the United States is an "in-network" physician for purposes of the plan. A list of in-network healthcare providers is available at http://www.bcbs.com. Non-Blue Cross/Blue Shield providers are considered "out-of-network" providers for purposes of the medical plan. The costs you incur in receiving medical treatment will vary depending on whether you see an in-network or out-of-network medical provider.

Additional details regarding the PPO program are set forth in "Preferred Provider Organization Health Benefits Program" document, which is attached to this Booklet as an Appendix. To the extent this Booklet and the Appendix conflict, the terms of this booklet control.

PRESCRIPTION DRUG COVERAGE AND BEHAVIORAL HEALTH BENEFITS ARE COVERED ELSEWHERE

The Fund provides prescription drug coverage and behavioral health (i.e., mental health and substance abuse) benefits to Fund participants and beneficiaries. Those benefits <u>are not</u> part of the PPO program. They are separate benefits that are discussed elsewhere in this SPD.

I. THE PATIENT PROTECTION AFFORDABLE CARE ACT

Our Plan is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to William Einhorn, Administrator, at the following address:

Teamsters Health & Welfare Fund
of Philadelphia and Vicinity
6981 North Park Drive, Suite 400
Pennsauken, NJ 08109

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

II. HOW THE PPO PROGRAM WORKS

Under the PPO program, your benefits are subject to a deductible, co-payments, coinsurance, and an out-of-pocket limit. You are not, however, required to obtain a referral in order to see a specialist. Likewise, the Fund has developed several programs to minimize your out of pocket expense when you need routine lab work, radiology examinations (e.g., x-rays or MRIs), and diabetic supplies. In addition, some of the covered services in the PPO program are offered at no expense to you.

A. Deductibles, Coinsurance, Co-Payments, and the Out-of-Pocket Limit

The specific deductibles, co-payments, and coinsurance provisions, and out of pocket limits applicable to you are set forth in Section III, below. As such, it is important to understand what those terms mean to you. A "co-payment" is a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. A "deductible" is the amount you owe for health care services the Fund covers before the Fund begins to pay. The deductible does not apply to services subject to co-payments. After you satisfy your deductible, you are responsible for coinsurance, which is your share of the costs of a covered health care service, calculated as a percentage (for example, 10%) of the allowed amount for the service. Once you satisfy your out-of-pocket limit, which does not include your deductible, for the year, you are no longer responsible for coinsurance, but you are still responsible for co-payments, balanced billed charges, any penalties, or health care the Fund does not cover.

B. In-Network versus Out-of-Network Care

An in-network health care provider is one who has agreed to accept the pre-negotiated allowable charges as payment in full for the services rendered. This means that the healthcare provider may not bill you for any charges in excess of the applicable co-payment, deductible, or coinsurance for the service rendered. Such additional charges are referred to as "balance billed charges." If you receive any balance billing from an in-network health care provider, please contact the Fund office for assistance.

Out-of-network providers have not agreed in advance to accept the Fund's allowable charges as payment in full for the services rendered to you. The Fund will pay most out-of-network providers a percentage of its allowable charges and you will be responsible for the balance of those allowable charges as well as deductible and coinsurance. If an out-of-network provider elects not to accept the Fund's allowable charges as payment in full, you will be responsible for paying any balance billed charges from the healthcare provider.

EXAMPLE: IN-NETWORK VS. OUT-OF-NETWORK PROVIDERS

1. In-Network Example

Bill goes to Dr. Smith, an in-network provider, because he thinks he has the flu. Bill has a $15 co-payment for the office visit and Dr. Smith bills the Fund $150 for the visit. The Fund's allowable charge for the office visit is $100. The Fund will pay Dr. Smith $85 for the office visit, and Dr. Smith will accept the $100 he has received from Bill and the Fund as payment in full for his services rendered.

2. Out-of-Network Example

Maria goes to Dr. Jones, an out-of-network provider, because she thinks she has the flu. Dr. Jones bills the Fund $150 for the visit. The Fund's allowable charge for the office visit is $100. Assuming Maria has satisfied her out-of-network deductible of $500, the Fund will pay Dr. Smith $80, which is 80% of the allowable charge, for the office visit. Maria will be responsible for at least $20 (20% of the allowable charge) and up to $70 if Dr. Jones declines to accept the Fund's allowable charge as payment in full and engages in balance billing.

C. Some of the PPO Program's Key Features

In addition to eliminating the need to obtain a referral to see specialists, the PPO program has several other key features that the Fund believes provide an exceptional value to Fund Members and their beneficiaries. Here are just some of the highlights of the program's in-network benefits:

1. Women may receive an annual mammogram with no out-of-pocket expense to them (additional screenings are subject to deductibles and coinsurance);
2. Women receive an annual routine gynecological examination with no out-of-pocket expense (additional examinations are subject to deductibles and coinsurance).
3. Men over the age of 50 may receive an annual prostate screening with no out-of-pocket expense (additional screenings are subject to deductibles and coinsurance);
4. Pediatric immunizations are covered with no out-of-pocket expense;
5. Beginning at age 50, the Fund covers one preventative colonoscopy every 10 years for each Member or Dependent beneficiary with no out-of-pocket expense (additional screenings are subject to deductibles and coinsurance); and
6. Numerous other benefits discussed in Section III, below.

Coverage for these benefits and other medical benefits is set forth in the PPO booklet appended to this Summary Plan Description. Please refer to that booklet for a description of these coverages, their limitations and applicable patient deductible, co-insurance and co-payment obligations.

SPECIAL BENEFIT TO PPO MEMBERS THROUGH
HEALTH CARE SOLUTIONS CORPORATION (HCSC)

The Fund has contracted with HCSC to provide an alternative, cost effective outpatient testing program that will save PPO participants and beneficiaries valuable health care dollars. The program covers all outpatient x-ray, medical imaging procedures, laboratory, pathology and cardiac stress testing. If your doctor has prescribed a covered outpatient medical test, you can save yourself money by using the HCSC outpatient testing benefit program. It's easy, simple and a substantial savings for you and your family.

Lab Work: If you use Laboratory Corporation of America (LabCorp) or Quest Diagnostics (Quest), or Health Network Lab facilities for outpatient laboratory services, no deductible, co-insurance or copayments will apply. Use of facilities other than these for such services will be covered under the benefit program, but will be subject to the deductible and co-insurance provisions set forth in the Summary of Benefits Schedule.

Radiology Examinations: You may obtain outpatient radiology services through the network of providers under contract with HCSC. Access to that network of providers may be obtained by calling HCSC at 1-800-655-8125 and getting precertified by HCSC for the examination in question. If a HCSC provider is utilized, a flat $20 copayment per session is applied. Use of other facilities for such services will be covered under the benefit program, but will be subject to the deductible and co-insurance provisions set forth in the Summary of Benefits Schedule.

Diabetes Management: If your doctor is treating you for Type I or Type II diabetes, you should contact HCSC for your important diabetic supplies. The Fund has arranged for brand name diabetic testing products to manage your diabetes testing care. The program covers the following: diabetic test strips; starter kits; test meters (free); syringes, lancets; alcohol swabs; replacement pen needles; and a sharps container.

In order to take advantage of the HCSC program, you should affix a HCSC sticker to the back of your Fund health program card (your Horizon Blue Cross/Blue Shield card) and tell the applicable benefit provider to bill the charges through HCSC and not Horizon. Stickers are available in your new Member kit or from the Fund office. If you would like to participate in the diabetes management program, you should contact HCSC directly at 1-800-655-8125.

PARTICIPANTS AND BENEFICIARIES ARE NOT REQUIRED TO PARTICIPATE IN THE HCSC PROGRAM. IN THE EVENT A PARTICIPANT DECLINES TO USE HCSC FOR A COVERED SERVICE, OUT OF POCKET EXPENSES WILL BE INCURRED PURSUANT TO THE SUMMARY OF MEDICAL BENEFITS IN SECTION III, BELOW.

D. Disease Management Program

The Fund has contracted with HealthCare Strategies to facilitate a Disease Management program, known as HealthReach. The purpose of the program is to educate members and their families concerning their individual health issues and, at the same time, monitor the quality of care our Members are receiving to be sure that they are getting the best service for the dollars the Fund and Members are spending for health care.

Based upon claims filed with the Fund, a HealthReach Care Counselor (a Registered Nurse) from HealthCare Strategies contacts the patient to ensure that the patient understands his/her medical condition and helps to coordinate his or her health care needs. Educational materials are provided to the patient. In some cases, the Care Counselor will contact the patient's treating doctors.

Participation in the Disease Management program has been mandatory since September 1, 2005. Plan Members and beneficiaries are REQUIRED to participate in the HealthReach program to ensure that the Fund is paying for appropriate services. If the patient refuses to participate in the program and cooperate with the HealthReach Care Counselor, a $500 penalty deductible (in addition to any other applicable deductible, co-insurance or co-payment) will be applied during each Plan Year to medical claims received after the patient receives final notice to contact the HealthReach Care Counselor.

III. THE PPO MEDICAL PROGRAM'S SUMMARY OF MEDICAL BENEFITS

The following schedule of medical benefits applies to the Fund's PPO program. In addition, you should refer to the separate Horizon Blue Cross/Blue Shield Member Handbook attached and incorporated by reference into this document as Appendix A. That booklet explains the medical, hospital and surgical program under which you are covered. If you did not receive a copy of Appendix A and are enrolled in this program, contact the Fund office at 1-800-523-2846.

BENEFIT PERIODS AND PARTICULARS

Benefit Period	Calendar Year
Program Deductible (Covered Person's Liability)	
(Preferred Care)	$225 per person per benefit period
(Non-Preferred Care)	$500 per person per benefit period
	This deductible applies to all services, except emergency care service, medical foods, pediatric immunizations, routine gynecological examination, pap smear and routine mammogram.
Family Deductible (Non-Preferred Care)	The family deductible amount is equal to 2 times the individual deductible. In each benefit period, it will be applied for all family members covered under a family coverage. A deductible will not be applied to any covered individual family Member once that covered individual has satisfied the individual deductible, or the family deductible has been satisfied for all covered family members combined.

Deductible Carryover	Expenses incurred for covered expenses in the last three months of a benefit period which were applied to that benefit period's deductible will be applied to the deductible of the next benefit period.
Coinsurance (Covered Person's Liability)	
(Preferred Care)	10%
(Non-Preferred Care)	20% for covered services; 50% for outpatient mental health/psychiatric visits; except coinsurance does not apply to emergency care services.
Annual Out of Pocket Limit	
(Preferred Care)	$500 per person
(Non-Preferred Care)	$1,500 per person
	When a covered person reaches the coinsurance out-of-pocket limit in one benefit period, the coinsurance percentage will be reduced to 0% for the balance of that benefit period. The dollar amounts specified shall not include any expense incurred for inpatient/out- patient mental health/psychiatric services, any deductible, penalty or copayment amount.
Annual Maximum	$2,000,000 per year per covered person for preferred and non-preferred covered services.

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SCHEDULE OF SERVICES

SERVICES	PREFERRED	NON-PREFERRED (% of Allowable Charge)
HOSPITAL		
Inpatient Services: Maximum of 365 days for preferred services; 70 days maximum for non-preferred services per illness The non-preferred days maximum is part of, not separate from, the preferred days maximum. *Note: precertification is required for inpatient services.*	90%	80%
Outpatient Services	90%	80%
EMERGENCY CARE		
Services within two (2) days of emergency certification of services must take place within two (2) business days of service, or as soon as reasonably possible, as determined by the Fund.	100%, less $100 copayment, waived if admitted	100%, less $100 copayment, waived, if admitted. Out-of-network charges for providers will be paid at 80% of charges.
Follow-up emergency room care within 14 days of initial treatment.	100%, less $100 copayment	100%, less $100 copayment
SURGICAL SERVICES		
If more than one surgical procedure is performed by the same professional provider during the same operative session, the Fund shall pay for the highest paying procedure and no allowance for additional procedures except where the Fund deems that an additional allowance is warranted.	90%	80%

SERVICES	PREFERRED	NON-PREFERRED (% of Allowable Charge)
ASSISTANT SURGEON	90%	80%
If more than one surgical procedure is performed by the same professional provider during the same operative session, the Fund shall pay the charge for the highest paying procedure and no allowance for additional procedures except where the Fund deems that an additional allowance is warranted.		
ANESTHESIA		
Services administered by a nurse anesthetist not employed by a professional provider are paid at 50%.	90%	80%
SECOND SURGICAL OPINION Voluntary	90%	80%
MEDICAL CARE		
Inpatient Care Concurrent Care (Inpatient consultations are limited to 1 consultation per consultant per confinement).	90%	80%
DIAGNOSTIC SERVICES - OUTPATIENT		
X-ray: Radiology, Ultrasound and Nuclear Medicine, ECG, EEG, Other.	90%	80%
Laboratory, Pathology	First $100 per benefit period payable @ 100%; 90% thereafter	80%

Note: Please see the comment regarding the Fund's special program through Healthcare Solutions on page 10.

SERVICES	PREFERRED	NON-PREFERRED (% of Allowable Charge)
Allergy Testing	90%	80%
THERAPY - OUTPATIENT		
Radiation Therapy, Chemotherapy and Dialysis Therapy	90%	80%
Infusion Therapy	90%	80%
Respiratory Therapy	100%, less $25 copayment per session	80%
Cardiac Rehabilitation Therapy 36 Preferred/Non-Preferred sessions per benefit period.	100%, less $25 copayment per session	80%
Pulmonary Rehabilitation Therapy 12 Preferred/Non-Preferred sessions per benefit period.	100%, less $25 copayment per session	80%
Physical Occupational, Speech Therapy	100%, less $25 copayment per session	80%
RESTORATIVE SERVICES		
-- Chiropractic services limited to 15 sessions per benefit period; -- Orthoptic pleoptic services limited to eight (8) visits per lifetime)	100%, less $25 copayment per session	80%
MATERNITY SERVICES		
Obstetrical/Maternity Care ***(Member or Spouse only)***	100% after $25 copayment for 1st visit	80%
Abortions (only to avert the death of the mother, or in the case of pregnancies resulting from rape or incest)	90%	80%
Newborn Care (from the date of birth to mother's discharge from the hospital)	90%	80%
SKILLED NURSING FACILITY CARE (SNF) (Hospital day limit maximum applies; precertification required)	90%	80%
Physician visit limits per benefit period: Two visits during first week of confinement and one visit per week for each consecutive week of confinement thereafter.	90%	80%

SERVICES	PREFERRED	NON-PREFERRED (% of Allowable Charge)
DURABLE MEDICAL/ SURGICAL EQUIPMENT Pre-certification is required for non-preferred supplies including all rentals and for the purchase of items with a billed amount that exceeds $500. (**Orthotics** are covered once every 24 months, with a benefit limit of $100 per foot appliance). *Orthotics reimbursed directly through the Fund, not Horizon Blue Cross.*	90%	80%
PROSTHETICS		
Pre-certification of non-preferred supplies is required for items with a billed amount that exceeds $500 in value.	90%	80%
HOME HEALTH CARE Must follow a one (1) day hospitalization and must be precertified	90%	80%
HOSPICE CARE	90%	80%
Respite Care - maximum of seven (7) days every six (6) months.	90%	80%
AMBULANCE		
MEDICAL FOODS AND NUTRITIONAL FORMULAS	90%	80%
(Deductibles do not apply to Medical Foods benefits, but they must be approved by the Fund office.)		
TRANSPLANT SERVICES	90%	80%
Coverage for charges of the donor is secondary to any other coverage the donor enjoys and is subject to a benefit maximum of $25,000 per transplant..		
OUTPATIENT PRIVATE DUTY NURSING	90%	80%

SERVICES	PREFERRED	NON-PREFERRED (% of Allowable Charge)
URGENT CARE CENTERS	$50 copayment per visit	80%
WALK-IN CLINICS	$25 copayment per visit	80%
PRIMARY CARE		
Home, office, outpatient visits and outpatient consultation with primary care physician	100%, less $15 copayment per visit	80%
Pediatric immunizations (copayments, deductibles and maximum amounts do not apply to this benefit).	100%	80%
Adult Preventive Care with primary care physician	100%, less $15 copayment per visit	80%
Specialist	100%, less $25 copayment per visit	80%
Routine annual Gynecological Exam and Pap Smears (copayments, deductibles and maximum amounts do not apply to this benefit).	100%	80%
Annual screening Mammogram (copayments, deductibles and maximum amounts do not apply to this benefit).	100%	80%
Therapeutic Injections	90%	80%
Allergy Extract/Injections	100%	80%
Compression Stockings (1 pair every six months)	90%	80%
Human Papilloma Virus (HPV) Vaccination	Lesser of the billed amount or $175.00, less $35 copayment	Lesser of the billed amount or $175.00, less $35 copayment

COVERED SERVICES LIMITATION

Services	Limitations
Inpatient Admissions/Services Mental Health/Psychiatric Services	Failure to precertify preferred services will result in a $1,000 reduction in benefits payable for selected

Alcohol, Drug Abuse and Dependency Skilled Nursing Facility Care Transplant Services Outpatient Services Surgical Services Home Health Care Hospice Care Private Duty Nursing	services. Failure to obtain pre-procedure certification for non-preferred services will result in a 20% reduction in benefits payable for selected services.
Disease Management Program	Failure to participate in the program will result in the assessment of a yearly penalty deductible of $500 in addition to all other applicable deductible, co-insurance and copayment provisions

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THE FUND'S BEHAVIORAL HEALTH PROGRAM AND HOW IT WORKS

Behavioral Health benefits (for the treatment of mental health and alcohol/substance abuse issues) must be coordinated, in advance through Total Care Network ("TCN"), the Fund's Behavioral Health Administrator. Total Care Network may be reached at 1-800-298-2299 or 1-215-425-8140 (24 hours a day / seven days a week for emergency services). This benefit is administered through both in and out-of-network of providers.

I. IN-NETWORK VERSUS OUT-OF-NETWORK CARE

The Fund, through Total Care Network, has contracted with a panel of licensed behavioral health providers. Providers on this panel have agreed to accept the Fund's allowance for particular behavioral health services as payment in full with no balance billing to the patient and without any up-front deductible or copayment. You will, however, be responsible for services excluded from coverage or which exceed the overall maximum benefit allowance for the patient for the plan year. Names of participating behavioral health providers may be obtained, without charge, from Total Care Network.

Total Care Network must precertify the need for behavioral health services, except in cases of emergency.

Total Care Network may be reached at 1-800-298-2299 or 1-215-425-8140 (24 hours a day / seven days a week for emergency services)

An out-of-network behavioral health provider is any licensed behavioral health provider of your choice that is not an in-network provider. The benefit payable will be limited to 80% of the Fund's allowance for participating providers. As a result, you may be subject to balance billing from an out-of-network provider.

II. MENTAL HEALTH/PSYCHIATRIC CARE

Benefits for the treatment of mental illness and serious mental illness are based on the services provided and reported by the provider. Those services provided by and reported by the provider as mental health/psychiatric services are subject to the mental health/psychiatric limitations in this program. When a provider renders medical care, other than mental health/psychiatric care, for a covered person with mental illness or serious mental illness, payment for such medical care will be based on the medical benefits available, and will not be subject to the mental health/psychiatric limitations in this program.

Preauthorization information must be submitted by the provider to TCN for review and evaluation so that a plan of treatment may be precertified for the covered person. Precertification must be obtained for all treatments, other than emergency care, in order to verify eligibility and to assure the medical appropriateness/necessity of the proposed treatment based on the nature and severity of the covered person's condition. In appropriate cases, a personal assessment by a preferred professional provider may be provided by the Fund at no cost to the covered person to accommodate the precertification process. **Emergency care is exempt from the requirements for precertification and will be considered preferred care.** However, emergency admissions or services must be reviewed and authorized within one business day of the admission or services, or as soon as possible thereafter as determined by the Fund and/or its Behavioral Health Administrator.

A. Inpatient Treatment

Benefits are provided, subject to the benefit period limitations stated in the Schedule of Benefits, for an inpatient admission for treatment of mental illness and serious mental illness. Inpatient visits for the treatment of mental illness and serious mental illness are covered when performed by a licensed professional provider/preferred facility provider.

For treatment of serious mental illness, the covered person may trade on a one (1) for two (2) basis, inpatient days for additional outpatient partial hospitalization days and outpatient facility/professional visits.

Covered services include treatments such as: psychiatric visits, psychiatric consultations, individual, family and Fund assessments, psychotherapy, electroconvulsive therapy and psychopharmacologic management.

B. Outpatient Treatment

Benefits are provided, subject to the benefit period limitations shown in the Schedule of Benefits for outpatient treatment of mental illness and serious mental illness. Outpatient mental health/psychiatric services shall be covered for the full number of outpatient session visits or an equivalent number of partial hospitalization visits per benefit period. Partial hospitalization is considered inpatient treatment. For treatment of mental illness, the covered person may trade off: (a) on a one (1) for two (2) basis, inpatient days for additional separate partial hospitalization services; or (b) on a one (1) for two (2) basis, inpatient days for additional outpatient visits. See the Schedule of Benefits for limits on the number of inpatient days that may be exchanged in any benefit period. For the treatment of serious mental illness, the covered person may trade on a one (1) for two (2) basis, inpatient days for additional outpatient partial hospitalization days/outpatient session visits. For maximum benefits, treatment must be performed by a preferred professional provider/preferred facility provider. All preferred outpatient services must be precertified by TCN.

Covered services include treatments such as: psychiatric visits, psychiatric consultations, individual, family and Fund assessments, psychotherapy electroconvulsive therapy, psychopharmacologic management, neuropsychiatric testing, and psychoanalysis. Benefits are not payable for the following services:

1. vocational or religious counseling;

2. activities that are primarily of an educational nature;

3. treatment modalities that have not been incorporated into the commonly accepted therapeutic repertoire as determined by broad-based professional consensus, such as primal therapy, rolfing or structural integration, bioenergetic therapy, and obesity control therapy; and

4. psychological testing.

C. Benefit Period Maximums for Mental Health/Psychiatric Care

All inpatient and outpatient mental health/psychiatric services for both mental illness and serious mental illness are covered up to the maximum day and visit limitations per benefit period specified in the Schedule of Benefits, below. Non-preferred benefit period maximums are part of, not separate from, preferred benefit period maximums.

III. TREATMENT FOR ALCOHOL OR DRUG ABUSE AND DEPENDENCY

Alcohol or drug abuse and dependency means a pattern of pathological use of alcohol or other drugs which causes impairment in social and/or occupational functioning and which results in a psychological dependency evidenced by physical tolerance or withdrawal. Benefits are payable for the care and treatment of alcohol or drug abuse and dependency provided by a hospital or facility provider, subject to the maximums shown in the Schedule of Benefits, according to the provisions outlined below. For maximum benefits, treatment must be received from a preferred provider.

Preauthorization information must be submitted by the provider to Total Care Network for review and evaluation so a plan of treatment may be precertified for the covered person. Precertification must be obtained for all treatments other than emergency care in order to verify eligibility and to assure the medical appropriateness/necessity of the proposed treatment based on the nature and severity of the covered person's condition. In appropriate cases, a personal assessment by a preferred professional provider may be provided by the Fund at no cost to the covered person to accommodate the precertification process.

If a patient is facing a crisis and is currently in treatment, contact should be made with the patient's therapist because he/she is most familiar with the patient's condition. **Emergency care is exempt from the requirements for precertification and will be considered preferred care.** However, emergency admissions or services must be reviewed and authorized within one business day of the admission or service, or as soon as possible as determined by the Behavioral Health Administrator.

A. Inpatient Detoxification

Inpatient covered services for detoxification shall be covered for 7 days per admission for detoxification with a lifetime maximum of 4 admissions for detoxification per covered person. Covered services are limited to:

1. Lodging and dietary services;
2. Physician, psychological, nurse, certified addictions counselor and trained staff services;
3. Diagnostic x-rays;
4. Psychiatric and medical laboratory testing;
5. Drug, medicines, use of equipment and supplies.

B. Hospital and Non-Hospital Residential Treatment

Hospital or non-hospital residential treatment of alcohol or drug abuse and dependency shall be covered on the same basis as any other illness covered under the program, but services are limited to 30 days per calendar year. Additional days may be available as specified below in "Outpatient Alcohol or Drug Services." There is a lifetime maximum of 90 days per covered person. Covered services include:

1. Lodging and dietary services;
2. Physician, psychological, nurse, certified addictions counselor and trained staff services;
3. Rehabilitation therapy and counseling;
4. Family counseling and intervention;
5. Psychiatric and medical laboratory testing;
6. Drug, medicines, use of equipment and supplies.

C. Outpatient Alcohol or Drug Services

Outpatient alcohol or drug services shall be covered for 30 full outpatient sessions or an equivalent number of partial hospitalization visits per calendar year. Benefits are available for an additional 30 separate sessions of outpatient or partial hospitalization services per year, which may be exchanged on a 2 to 1 basis to receive up to 15 more days of non-hospital residential alcohol or drug treatment (i.e., the covered person may trade off on a 2 for 1 basis, up to 30 separate sessions of outpatient services per year, in order to receive up to 15 additional days of hospital and non-hospital residential alcohol or drug abuse treatment days). Any benefits exchanged or traded off under terms of this provision are subject to, and do not increase, the overall lifetime maximum.

There is a lifetime maximum of 120 full session visits or an equivalent number of partial hospitalization visits per covered person. Partial hospitalization is considered as inpatient treatment. Covered services include:

1. Physician, psychological, nurse, certified addictions counselor and trained staff services;
2. Rehabilitation therapy and counseling
3. Family counseling and intervention;
4. Psychiatric and medical laboratory testing;

5. Drug, medicines, use of equipment and supplies.

IV. BEHAVIORAL HEALTH SUMMARY OF BENEFITS

	In-Network	Out-of-Network
Psychiatric Care:		
Inpatient; Lifetime maximum of 50 days (in or out-of-network combined)	100%, up to 30 days per Benefit Period	80% of allowance, up to 20 days per Benefit Period
Outpatient	100% of allowance, max of 30 visits per Benefit Period	80% of allowance, max of 20 visits per Benefit Period
Alcohol/Drug Abuse Treatment:		
Inpatient Detoxification – 7 days per admission; lifetime maximum of 4 confinements	100%	80% of allowance
Residential Care – 30 days per Benefit Period; Lifetime maximum of 90 days	100%	80% of allowance
Outpatient care – 30 full session visits; Lifetime maximum of 120 visits	100%	80% of allowance

Failure to precertify non-preferred inpatient services will result in a $1,000 reduction in benefits payable for selected services.

Remember: you must contact Total Care Network at 1-800-298-2299 to coordinate Behavioral Health/Substance Abuse services.

A Note Regarding the Mental Health Parity Act:

The Fund's plan of benefits will not be subject to the federal Mental Health Parity and Addiction Equity Act until January 1, 2016 because the last collective bargaining agreement applicable to the Fund entered into before the effective date of that law does not expire until 2015.

THE FUND'S PRESCRIPTION DRUG PROGRAM

The Fund provides benefits for prescription drugs or refills of them when dispensed by a pharmacy pursuant to a physician's prescription. These benefits are subject to a patient co-pay for each prescription or refill. Consult the Summary of Benefits Schedule, below, for further details. In addition, benefits are provided for insulin, disposable syringes to be used in administering the insulin (whether or not you have a prescription for the insulin or these disposable syringes) and other diabetic supplies.

I. HOW THE PRESCRIPTION DRUG PROGRAM WORKS

The Fund has contracted with a pharmacy benefits manger (PBM) to provide its members and their covered dependents with affordable prescription drug benefits. The Fund's current PBM is OptumRx. All Fund members and their covered dependents should have an OptumRx membership card in addition to his or her Horizon Blue Cross/Blue Shield Card. If you do not have such a card, please contact the Fund office for assistance.

When you go to a pharmacy to have a prescription filled, you should present your PBM card to the pharmacy staff. Your card will be scanned and the appropriate co-payment applied to your purchase(s). The amount of your co-pay will depend on the type of prescription you have filled. Additional information regarding the co-payment amounts is set forth below in the Summary of Benefits Schedule, below.

II. MAIL ORDER PROGRAM

The Fund's prescription drug program also has a mail order option that can make purchasing your prescription drugs even more affordable. If you have been prescribed a maintenance medication, you may use the Fund's mail order program to order a 90-day supply of your medication for a single co-payment. Additional information about the mail order program is available from the Fund office or on the Fund's website.

EXAMPLE:

Adam has been prescribed medication to treat his blood pressure. That medication is a maintenance medication under prescription drug program formulary and is available as a generic. Adam receives a 90 day prescription for his medication from his physician and utilizes the Fund's mail order program. In response, Adam is charged a $3 co-payment for 90 days of medication, instead of $3 every 30 days if he went to a retail pharmacy to have his prescription refilled.

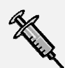
III. THE PRESCRIPTION DRUG PROGRAM'S LIMITATIONS

The Fund's prescription drug program is subject to certain limitations and exclusions. For example, the Fund will not pay any of the cost for:

1. vitamins (whether formulary or non-formulary);
2. cosmetics or other health and beauty aids
3. bandages and similar supplies
4. dietary aids
5. support garments (other than compression stockings as provided in the Summary of Benefits schedule)
6. prescription drugs prescribed for smoking cessation
7. other non-prescription substances
8. therapeutic devices and appliances
9. drugs available over-the-counter (except proton pump inhibitors and non-sedating antihistamines that are prescribed in lieu of non-over-the-counter equivalents)
10. contraceptives, unless pre-approved by the Fund, for the treatment of a medical condition
11. medications to treat erectile dysfunction unless such dysfunction is secondary to another medical condition and is preapproved by the Fund
12. drugs or compound drugs that have not been approved by the Federal Food and Drug Administration
13. administration or injection of any drug
14. hypodermic needles and syringes (other than described above)

In addition to the above items, the Fund will not pay for the refill of covered prescription drugs in excess of the number of refills specified by the physician, or any refill dispensed after one year from the date of the physician's latest order. The program does not cover drugs otherwise provided for under the Fund's Hospital, Medical and Surgical program, nor does it cover drugs otherwise provided for under any government program or law or workmen's compensation or occupational disease laws. The Fund also does not cover more than a 34 day supply of any covered prescription drug, except for certain maintenance drugs that are eligible to be filled for a 90 day supply under the mail order program described above.

Pre-approval is required for any prescription for (1) injectible drugs that cost more than $1,500 (OptumRx approval required); (2) drugs for which the cost of a one month supply exceeds $1,500 (Fund approval required); (3) drugs to treat erectile dysfunction (which will only be approved by the Fund in those cases in which the condition is secondary to another medical condition); or (4) newly released drugs that have not been approved by the Federal Drug Administration for more than six (6) months (Fund approval required).



A NOTE ABOUT INJECTIBLES

Regardless of whether they are going to be administered by a healthcare provider in a clinical setting, injectible medication or treatment, with the exception of insulin and oncology related products, must generally be purchased through the Plan's prescription drug program in order for them to be covered by the Plan. Thus, if your physician intends to administer an injectible medication or treatment to you, you must purchase it yourself through OptumRx's specialty pharmacy and take it to your healthcare provider to be administered or have it shipped directly to your provider.

STEP THERAPY:

Your pharmacy benefits plan includes OptumRx's step-therapy program. Step-therapy is a type of precertification. Under the step-therapy program, certain drugs are not covered unless you have tried one or more "prerequisite therapy" medication(s) first. Certain over the counter "prerequisite therapy" medications, such as non-sedating antihistamines (e.g., Allegra and Claritin), may purchased at the generic copay price when they are purchased subject to a prescription at a participating pharmacy. However, if it is medically necessary for you to use a step-therapy medication as initial therapy without trying a prerequisite therapy drug, your doctor can request coverage of the step-therapy medication as a medical exception by contacting OptumRx at the telephone number listed on your OptumRx ID card. Any prescription strength non-sedating antihistamines will not be eligible for a generic co-pay, but rather will be billed at the third-tier co-pay.

YOUR PHARMACY CARD IS ONLY VALID AS LONG AS YOU MAINTAIN YOUR ELIGIBILITY. SHOULD YOU USE YOUR CARD WHEN YOU ARE INELIGIBLE, YOU WILL BE LIABLE FOR THE CHARGES. DRUGS DISPENSED PRIOR TO THE EFFECTIVE DATE OF COVERAGE UNDER THIS PLAN OR AFTER THE DATE SUCH COVERAGE TERMINATES ARE NOT COVERED.

IV. PRESCRIPTION DRUG SUMMARY OF BENEFITS SCHEDULE

Type of Drug	Copayment
Generic	$3.00
Formulary Drugs (Preferred)	$10.00
Non-Formulary Drugs (Non-Preferred)	50% of the drug cost with a *minimum* copayment of $30.00 and a *maximum* of $40.00

A current listing of the Fund's prescription drug formulary and maintenance drug formulary is available on the Fund's website at http://www.teamsterfunds.com and is also available upon request from the Fund office.

LIMITATIONS ON COVERAGE FOR THE DRUG SUBOXONE

EFFECTIVE MARCH 1, 2013, THE FUND WILL COVER A SINGLE COURSE OF TREATMENT UTILIZING THE DRUG SUBOXONE FOR A PERIOD NOT TO EXCEED THREE (3) MONTHS PER LIFETIME.

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THE FUND'S DENTAL PROGRAM

The Fund maintains a dental program for its Members and their beneficiaries. The dental benefits provided are equal to the actual charges made by a dentist for care and treatment, but will not exceed the allowed amount listed for each procedure in the Summary of Benefits Schedule. The dental benefit, like the medical and behavioral health benefits, is administered through both in-network and out-of-network of dentists.

I. IN-NETWORK VS. OUT-OF-NETWORK

A. In-Network

The Fund has contracted with a panel of dentists practicing general dentistry as well as in the specialized fields of dentistry. Dentists on this panel have agreed to accept the Fund's allowance for particular dental services as payment in full with no balance billing to the patient, unless a copayment applies to the service. You will, however, be responsible for services excluded from coverage or which exceed the overall maximum benefit allowance for the patient for the plan year. A listing of the panel members can be obtained, without charge, from the Fund office or on the Fund's web site.

B. Out-of-Network

The Fund's maximum allowance for out-of-network dentist is that which is shown in the Summary of Benefits Schedule and you may be responsible for any balance charged by the provider if the dentist declines to accept the Fund's allowance as payment in full.

II. BENEFITS PROVIDED

The Fund has a complete "Dental Table of Allowances." Please write the Fund or check the Fund's website (www.teamsterfunds.com) if you want to know the Schedule of Allowances for any procedure not listed in the Summary of Benefits Schedule. You should contact the Fund office before you start any non-emergency work to obtain the appropriate claim forms and to ensure that you are covered for benefits.

BENEFITS ARE PAYABLE ONLY IF YOU ARE ELIGIBLE AT THE TIME EACH PROCEDURE IS PERFORMED.

A. Annual Allowances

Family Member Calendar Year Maximum..$2,000
(*This maximum does not include any orthodontia payments*)

Orthodontia – Per Eligible Dependent Lifetime Maximum……….…………………..$3,400

(Orthodontia benefits available only for dependent children between the ages of 10 and 18, inclusive. Phase I orthodontia expenses are generally not covered, but may be covered based upon a predetermination/precertification. Any approved Phase I orthodontia expenses are applied against the Family Member Lifetime Orthodontia Maximum.)

A SPECIAL NOTE REGARDING ORTHODONTIA BENEFITS

Orthodontic care is available only to your unmarried dependent children between the ages of 10 and 18 inclusive. Full cases, requiring 24 or more months of care, will be paid at the maximum benefit. Partial cases will be paid at a lesser allowance. All cases must be rated by the Fund's orthodontic consultants. The Fund's maximum allowance and payment schedule for orthodontia care is shown in the Summary of Benefits Schedule. Orthodontic benefits are a lifetime benefit and not included in calculating the patient's yearly dental maximum. Orthodontia benefits are paid on a quarterly basis and will be prorated if a Member is ineligible for part of the quarter in question.

B. Schedule of Dental Benefits

The Fund has set allowances for all covered dental procedures. As previously noted, a complete listing of those covered procedures and allowances may be obtained at the Fund office or from the Fund's web site (www.teamsterfunds.com). The maximum allowance may not exceed the fee actually charged for the procedure. This Table of Allowances will apply to all. For any procedure which has an allowance that is different from Members or Dependents over the age of 14 and for Dependent Children between the ages of 0 and 14, the description indicates "adult" or "child."

No payment will be made until the required dental claim form has been completed by the attending dentist and approved by the Fund. Benefit payments will be calculated with reference to the dental allowances set by the Fund's Trustees, less any applicable patient copayment. The following patient copayments apply to dental procedures:

Service	Copayment
Preventative services (yearly and periodic exams, x-rays, cleanings)	$0
Restorative services (amalgam and composite fillings, etc.)	$0
Fixed prosthodontics (crowns and bridges)	$30 per tooth
Removable prosthodontics (full or partial dentures)	$50 per unit
Periodontal surgery	$25 per quadrant
Endodontic surgery (root canal, etc.)	$25 per tooth
Oral surgery	$25 per tooth
Orthodontic care	$100 per case

C. Dental Benefit Limitations

EMERGENCY CARE: If you have a dental emergency, you may go directly to your dentist for emergency treatment. However, the Fund will pay only for dental treatment in accordance with the Dental Table of Allowances available on the Fund's website and from the Fund office.

If you are in an automobile accident, the Fund is your secondary carrier if a claim related to that accident arises. In other words, the Fund will only consider for payment those charges not paid under your automobile insurance policy and in certain cases only up to a certain limit. (See "Automobile Insurance" under General Provisions and Definitions.) Also, please remember that the Fund has the right of subrogation when you are involved in any accident and where you recover any expenses which have been paid to you under this Plan from a third party.

No dental expense benefits are provided for the following:

1. Routine dental examinations performed more frequently than once in any six (6) consecutive month period.

2. Prophylaxis (cleaning of teeth) expenses in excess of the amount shown in the Summary of Benefits Schedule more often than once during any six (6) month period.

3. Dental treatments and services in connection with dentures, bridgework, and crowns will not be covered:

   a. If the work in making the denture, bridge or crown started prior to the effective date of coverage of the individual; however, insertions occurring while the member is eligible will be covered; or

   b. If expenses are for more than one denture, either full or partial, or for any bridge or crown within any five year period.

4. Treatment by other than a licensed dentist, except charges for dental prophylaxis (cleaning of teeth) under the direction of a licensed dentist.

5. Orthodontic care falling outside of the age and lifetime maximum limitations (see above for details).

THE FUND'S DISABILITY BENEFITS PROGRAM

I. THE PROGRAM

If you, prior to retirement, become disabled from a non-occupational accidental injury or disease, and will be prevented by such disability from performing any and every duty pertaining to your occupation, payment will be made to you as determined from the Summary of Benefits Schedule. Any such payment is limited to a maximum period of 26 weeks during any one continuous period of disability whether from one or more causes and is contingent upon receipt of a Weekly Disability claim form, containing proof of disability satisfactory to the Trustees. Benefits are payable only while you are under the care of, and treated personally by, a legally qualified physician or surgeon.

Successive periods of disability will be considered as having occurred during one period of disability unless the subsequent period is due to causes completely and entirely unrelated to the prior accident or disease or unless the prior and subsequent periods are separated by a resumption of active employment for a period of thirty (30) or more full calendar days.

Disability benefits are available to Fund Members only. Spouses and other Dependent beneficiaries are ineligible for disability benefits.

II. LIMITATIONS

The Fund's disability benefit program, like its other programs, is subject to certain limitations. **First**, a disability, to be covered, must commence while you are eligible for Fund benefits. The beginning date of your claim (disability) is determined from the date you are first seen and treated by a physician for it, which may differ from the date of your injury. **Second**, this benefit is paid in lieu of wages; thus, you must not be earning wages from your Employer in order to be eligible for this benefit. **Third**, your weekly disability benefit will be reduced by any short-term disability or wage loss benefit payable to you under any applicable automobile no-fault policy, program, or any other law or regulation. This includes, without limitation, any disability benefits provided under state law such as New Jersey's temporary disability benefits, or those benefits provided under federal law such as Social Security Disability Insurance ("SSDI"). **Fourth**, weekly disability benefits will not be payable to a Member whose disability resulted from participation in or in consequence of having participated in an illegal act which is in violation of any federal or state criminal statute relating to the possession of controlled substances. **Fifth**, you must be under the care of a legally qualified physician or surgeon and receiving appropriate care and treatment for your condition.

III. SUMMARY OF BENEFITS

Weekly disability benefits are payable as follows:

1. $250.00 per week; or
2. $50 per work day

If, however, you work for a New Jersey Employer covered under the New Jersey Temporary Disability Law, you will receive a benefit equal to ½ of the disability payment indicated above. Disability benefits will commence on the first work day if the disability results from an accident or hospitalization. Benefits will commence on the sixth work day if the disability is a result of a sickness or pregnancy. Weekly disability benefits are payable for a maximum of 26 weeks. The Fund will pay you weekly disability benefits upon the initial denial of a workers' compensation claim, if you execute a Fund approved subrogation agreement.

THE FUND'S LIFE INSURANCE PROGRAM

I. HOW THE LIFE INSURANCE PROGRAM WORKS

The Fund maintains a life insurance program for your benefit and your beneficiaries' benefit in the event of a Member or Dependent beneficiary's death from a covered cause. In the event of your death from a covered cause, a "death benefit" will be paid to the Member's designated beneficiary of record. In the event of the death of any other eligible dependent from a covered cause, payment will be made directly to the Member.

Oftentimes, the "death benefit" is used to defray the costs of burying a loved one. As a result, a payment of all or a portion of the death benefit may be made directly to a funeral home, provided the Fund receives from the beneficiary of record an appropriate, written and signed assignment of benefits. A funeral home can usually assist in furnishing the necessary paperwork.

Unlike other benefits offered through the Fund’s program that are self-insured, the death benefit for active employees and their dependents is a fully-insured benefit purchased by the Fund on a group basis through the Aetna Life Insurance Company. The amount of payment is that shown in the Summary of Benefits Schedule. Additional details regarding the Fund's death benefits are found in the Summary of Benefits Schedule as well as in the Aetna Life Insurance Company document, which may be requested from the Fund office.

II. CONTINUANCE OF MEMBER DEATH BENEFIT IN THE EVENT OF TOTAL DISABILITY

If, while he or she is eligible, a Member becomes totally disabled, his or her death benefit coverage as determined from the Summary of Benefits Schedule will continue after his or her eligibility stops provided:

1. The Member provides the Fund with written proof, satisfactory to the Trustees or Administrator, that he or she is Totally Disabled. THIS WRITTEN PROOF MUST BE PROVIDED TO THE FUND WITHIN SIX MONTHS OF THE DATE ON WHICH THE PARTICIPANT FIRST RECEIVED ORAL OR WRITTEN NOTICE FROM THE SOCIAL SECURITY ADMINISTRATION, A PHYSICIAN, A HEALTH PROVIDER, OR ANY OTHER SOURCE THAT HE OR SHE IS TOTALLY DISABLED. Contact the Fund office for this special form.

2. During the last three months of each subsequent year that the Member remains Totally Disabled, he or she must provide the Fund with written proof of his or her continuing disability. This written proof must be in a form satisfactory to the Trustees or the Administrator.

3. If the Member dies before the expiration of the six month period set forth in paragraph 1, above, then within one year of his or her death the Member's beneficiary of record must provide the Fund with written proof, satisfactory to the Trustees or Administrator, that the Member remained Totally Disabled from the onset of the total disability through the date of his or her death.

4. This benefit does not apply in the case of a spouse or other beneficiary of a Member.

If you apply for disability benefits from the Social Security Administration at any time after you cease working, then you must send a copy of your application and all supporting documentation to the Fund within ninety (90) days after you file the application with the Social Security Administration.

III. BENEFICIARIES

Each Member has the sole right to designate the beneficiary to whom his or her Death Benefit shall be payable. This designation is one of the records which the Fund office maintains along with census information. A Member may change his or her designation at any time, but must do so in writing. Any changes in beneficiary will take effect on the day the signed request is received in the Fund office, but never before then.

If a Member has more than one beneficiary when he or she dies, and he or she has not specified their respective interests, they all share equally. If any beneficiary dies before the Member, the deceased beneficiary's rights and interest will automatically terminate.

If a designated beneficiary does not file a claim for Death Benefits within one year from the date of the Member's death and the whereabouts of this designated beneficiary are unknown, the Fund shall insert an advertisement in a newspaper of general circulation in the last known place of residence of this designated beneficiary as shown by the Fund's records, to the effect that if the designated beneficiary does not file a claim within ten (10) days of the advertisement, the Trustees will pay the Death Benefit, without interest, to the Member's estate or next of kin as set forth below.

If the Member has not designated a beneficiary or the beneficiary he or she named is no longer living, or fails to file a Death Benefit claim after the advertisement described above, then the Fund may, at its option, pay an amount not to exceed $1,000.00 to any person or persons who may have incurred expenses in connection with your last illness or burial. The balance of the member's Death Benefit, if any, shall be paid to:

1. Your surviving spouse, or, if none
2. Equally to your surviving children, or, if none,
3. Your parent(s), or, if none
4. Your surviving sibling(s), or, if none,
5. The personal representative of your estate without restriction to the foregoing order.

In this regard, the term "sibling" shall include only those persons who share at least one parent with the decedent, either by birth or legal adoption. Furthermore, if any person to whom the death benefit is payable has not reached the age of eighteen (18) as of the time of payment and for whom a guardian of the estate of the minor has not been appointed, then in such event the Fund shall establish a trust account of the benefit of the minor at a federally regulated bank or similar institution.

IV. **BENEFITS**

The following benefits are payable under the Fund's life insurance program:

Event	Amount Payable
Death of Member	$20,000
Death of Member when death benefit continues in force on Member during a period of total disability	$3,000
Death of Spouse	$1,500
Death of Dependent Child in accordance with age as follows:	
----Over 14 days, but less than six months	$300
----Six months, but less than two years	$600
----Two years, but less than three years	$1,200
----Greater than three years	$1,500

THE FUND'S ACCIDENTAL DEATH & DISMEMBERMENT ("AD&D") PROGRAM

I. HOW THE PROGRAM WORKS

If, as a result of external, violent and Accidental Bodily Injury, a Member suffers the loss of life, limb or sight, and if such loss occurs within twenty-six (26) weeks following the date of the accident, the Fund will pay AD&D benefits as specified in the Summary of Benefits Schedule upon receipt of proof of such loss satisfactory to the Fund's Trustees or Administrator.

AD&D benefits will be paid for each loss without regard to previous losses, provided that the total amount payable due to two or more losses sustained by you in all accidents does not exceed the principal sum as determined in the Summary of Benefits Schedule.

Unlike other benefits offered through the Fund's program that are self-insured, the accidental death and dismemberment benefit, like the life insurance benefit, is a fully-insured benefit purchased by the Fund on a group basis through the Aetna Life Insurance Company.

II. BENEFITS PROVIDED

AD&D benefits are payable subject to the following qualifying schedule:

Losses Covered	Amount of Benefit
Loss of Life	$20,000
Both Hands or Both Feet	$20,000
Sight of Both Eyes	$20,000
One Hand and One Foot	$20,000
One Hand and Sight of One Eye	$20,000
One Foot and Sight of One Eye	$20,000
One Hand or One Foot	$10,000
Sight of One Eye	$10,000

"Loss of Sight" means: Total and irrecoverable loss of sight. Loss of Hand or Foot means: Loss by severance at or above wrist or ankle.

III. LIMITATIONS

The AD&D benefit is subject to the following limitations:

A. The Claim Date is the date of death or, in the event of loss of sight or dismemberment, the date of the accident; and

B. Accidental Death and Dismemberment does not cover any loss resulting from or caused directly, in whole or in part, by

1. Disease or bodily or mental infirmity or medical or surgical treatment thereof,
2. Ptomaine or bacterial infections, except pyogenic infections occurring with and through an accidental wound,
3. Suicide or intentionally self-inflicted injury, while sane or insane,
4. Participation in or in consequence of having participated in an illegal act which is in violation of any federal or state criminal statute, including driving a motor vehicle while intoxicated
5. Flying, unless you were a passenger on a commercial airline, or
6. War or any act of war, whether declared or undeclared, or insurrection, or
7. Drug overdose, whether intentional or unintentional.

THE FUND'S VISION CARE PROGRAM AND HOW IT WORKS

I. GENERAL INFORMATION

The Fund's vision care benefit, like the medical, dental, and behavioral health benefits, is administered through both in and out-of-network (see note below) eye doctors. In-Network providers have agreed to accept the Fund's reimbursement rates as payment in full for covered services, while out-of-network providers have not. The Fund will send to you, without charge, a list of doctors who have agreed to accept the Fund's allowance as payment in full when particular material is selected. This listing is also available on the Fund's web site. Thus, your services with an out-of-network provider MAY be subject to balance billing for charges in excess of the Fund's allowance for the following services.

TYPE OF BENEFIT	AMOUNT OF BENEFIT
Eye Examination (one every 24 months)	$40
Frames (one pair every 24 months)	$27
Lenses (one pair every 24 months) ----Single Vision ----Bifocal ----Trifocal ----Lenticular	 $33 $37 $42 $115
Contact lenses (one pair every 24 months)	$60

II. LIMITATIONS

Benefits under this program are payable only for services rendered every twenty-four (24) months. Lenticular Lenses are covered only when they are prescribed in connection with cataract surgery. A Plan Member or Dependent beneficiary will be eligible for a new pair of glasses following cataract surgery even if it has been less than twenty-four (24) months since the Member or Dependent beneficiary obtained a new pair of lenses.

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GENERAL LIMITATIONS AND EXCLUSIONS APPLICABLE TO ALL OF THE FUND'S BENEFITS

In addition to the limitations and exclusions specific to each type of benefit the Fund offers, there are certain general limitations and exclusions that each Fund Member and Dependent beneficiary should be aware of.

I. IMPORTANT NOTE REGARDING THE RELATIONSHIP BETWEEN THE FUND AND HEALTH CARE PROVIDERS

No health care provider is an agent or representative of the Fund. The Fund does not control or direct the provision of health care services and/or supplies to Fund members or their covered dependents by anyone. The Fund makes no representation or guarantee of any kind concerning the quality of health care services or supplies furnished by any provider.

The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the Plan of Benefits. The statement also applies to all entities (their agents, representatives and employees) that contract with the Fund to offer preferred provider networks or other health-related supplies to Fund members and their covered dependents. Nothing in this Plan affects the ability of a health care provider to disclose alternative treatment options to a Fund Member or covered dependent. Although subject to benefit allowances and limitations in the Plan with regard to payment, the choice of a provider and/or treatment remains with the patient.

II. GENERAL EXCLUSIONS

In addition to the exclusions provided elsewhere in this Booklet or the exclusions set forth in the Horizon Blue Cross PPO booklet, benefits are not payable for the following:

A. Charges arising from, or occurring in the course of, any gainful occupation or employment, unless the Fund receives a copy of a final order from the appropriate court or other agency determining that a claim is not covered under the applicable workers' compensation statute. This exclusion applies regardless of whether a claim is actually made or filed under any applicable workers' compensation statute or program.

B. Charges for services or supplies which are not Medically Necessary or Medically Appropriate as determined by the Fund, its Claims Administrator and/or its Medical Consultant.

C. Charges for treatments or procedures that are experimental or investigative.

D. Charges for treatments which are not approved by the Member or Dependent beneficiary's attending physician.

E. Charges which are not Usual, Customary and Reasonable as determined by the Fund's Trustee or Administrator.

F. Charges in excess of the payment the provider of service accepted as payment in full from any other source.

G. Charges for custodial care or for maintenance of chronic conditions.

H. Charges for services rendered by a Member of the patient's immediate family (including in-laws).

I. Charges that are made only because this coverage exists, or charges that no covered individual is legally obligated to pay.

J. Charges for treatments, services and/or supplies provided, ordered or required by the United States government, or any other government (including court-ordered treatment).

K. Charges resulting from war or service connected injuries or diseases.

L. Charges associated with any treatment for weight reduction.

M. Charges for hearing aids or the examination and fitting of hearing aids.

N. Charges to the extent that they are recovered from any person or organization other than an insurer of the patient.

O. Charges for cosmetic treatment and/or surgery for purposes other than breast reconstruction following a mastectomy, correction of damages caused by accidental injury, or for correction of a birth defect, provided that the patient was covered under this Plan on the date of the accident or date of birth and is still eligible as of the date of the cosmetic treatment or surgery.

NOTE:

SURGERY GENERALLY CONSIDERED COSMETIC IN NATURE (EVEN THOUGH FOR MEDICAL REASONS) REQUIRES PRIOR APPROVAL.

P. Charges for the diagnosis and treatment of dislocations, strains, sprains or misplacements of the skeletal structure (pertaining to the skeleton) or musculature (the system of muscles), except for the first fifteen (15) visits with a physician in any calendar year or when requiring the administration of a general anesthesia, an opening or cutting operation, or confinement in a hospital.

Q. Charges for orthotic shoe inserts (unless specifically covered under your Summary of Benefits Schedule).

R. Charges for immunizations and vaccines (unless specifically covered under the Horizon Blue Cross PPO Program)

S. Charges for eye exercises, psychological testing, and learning disabilities, school or DOT physicals.

T. Charges for Counseling, including marriage counseling or group therapy.

U. Charges for treatment of temporomandibular joint dysfunction in excess of any coverage under the Fund's Dental Benefit Plan.

V. Charges for sex change operations.

W. Charges for penile prosthetic devices.

X. Charges for the surgical correction of myopia, including without limitation Lasik.

Y. Charges for oral and implantable contraceptive drugs and devices, except when prescribed to treat certain medical conditions.

Z. Charges for treatment of infertility, including, but not limited to, in-vitro fertilization, artificial insemination, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and/or reversal of a sterilization procedure.

AA. Charges for any other medical, dental, vision, or pharmacy service except as provided in your appropriate Summary of Benefits Schedule.

BB. Charges related to genetic counseling or genetic testing, except when such charges are incurred to determine the efficacy of certain medications or course(s) of treatment.

CC. Charges for diabetic shoes are not covered.

Also, benefits will only be paid in accordance with provisions of the Fund's various Plans. For example, Vision Care is provided for under its Vision Care Plan and will not be provided under any other provision of the Plan unless specifically included in such other Plan provision.

III. IMPORTANT LIMITATIONS REGARDING MOTOR VEHICLE ACCIDENTS AND THE FUND'S SUBROGATION RIGHTS, GENERALLY

A. Motor Vehicle Accidents

All Members and beneficiaries must understand that the Fund is your secondary source of benefits when an automobile accident claim arises. In other words, the Fund will only consider for payment those charges not paid under your automobile insurance policy and in certain cases only up to a certain limit. (See "Automobile Insurance" under General Provisions and Definitions.)

B. Subrogation/Reimbursement

Keep in mind that the Fund has the right of subrogation when you are involved in any accident and/or where you recover any expenses which have been paid to you under this Plan from a third party. This means, generally, that the Fund may recover from you any benefits it has paid on your behalf if you recover from any third party. This includes, without limitation, motor vehicle accident recoveries, personal injury suits, and medical malpractice claims.

The following specific rule applies to any situation in which the Fund makes any full or partial payment to or on behalf of a Member or Dependent (other than for death benefits) who subsequently recovers from any other source additional payments or benefits in any way related to the accident, illness, or treatment for which the Fund made full or partial payment:

1. Upon any such subsequent recovery by or on behalf of a Member or Dependent beneficiary, from any person or persons, party or parties, insurance company, firm, corporation, or government agency, whether by suit, judgment, settlement, compromise, or otherwise, the Fund, with or without the signing of a subrogation/reimbursement agreement, shall be entitled to immediate reimbursement to the extent of benefits paid to or on behalf of the Member or Dependent.

2. The Fund shall be first reimbursed fully by or on behalf of such Member or Dependent to the extent of benefits paid from the monies paid by any person or persons, party or parties, insurance company, firm, employee benefit plan, corporation, or government agency and the balance of monies, if any, then remaining from such subsequent recovery shall be retained by or on behalf of the Member or Dependent.

3. The Member or eligible dependent shall hold, as a fiduciary in constructive trust for the benefit of the Fund, any monies so recovered that are subject to the Fund's subrogation/reimbursement lien or these provisions.

4. All Members and Dependents are obligated to cooperate with the Fund in its efforts to enforce its subrogation rights and to refrain from any actions which interfere with those efforts. This duty of cooperation includes (but is not limited to) the obligation to sign a subrogation/reimbursement agreement in a form prescribed by the Fund.

5. The Fund shall have the right to take all appropriate actions necessary to enforce its subrogation rights in the event that a Member or Dependent refuses to sign a subrogation/reimbursement agreement, refuses to reimburse the Fund in accordance with the Fund's subrogation rights, or takes any other action inconsistent with the Fund's subrogation rights. In such situations, the Fund's options shall include, without limitation: the right in appropriate cases to deny benefits to an individual who refuses to sign a subrogation/reimbursement agreement; to institute legal actions to recover sums wrongfully withheld or to obtain other relief; and/or to offset wrongfully withheld sums against future benefit payments otherwise owed the individual who retains such sums.

6. The Fund may pay counsel fees in an amount not to exceed 20% in order to protect the Fund's subrogation interests.

HOW TO FILE A CLAIM FOR FUND BENEFITS AND APPEAL A DENIAL OF A CLAIM

I. HOW TO FILE A CLAIM FOR FUND BENEFITS

A. Medical Benefits

The medical plan identification card is the easiest way to file a claim for medical benefits. Generally, a health care provider will submit medical or dental claims on a Member or Dependent beneficiary's behalf in accordance with the information on the medical plan identification card. The Fund accepts universal claim forms from health care providers. In the event a healthcare provider does not submit a claim with the Fund directly, claim forms are available on the Fund's website, from the Fund office, or participating Employers in some cases.

In those limited circumstances in which a paper claim form is required, Members and beneficiaries can help us process claims in a speedy and accurate fashion by providing the necessary information. Just check the appropriate block at the top of the claim form and follow the instructions provided to obtain benefits. Much of the delay in processing claims is directly related to incomplete or incorrectly completed claim forms being submitted to the Fund or Horizon Blue Cross.

B. Dental Benefits

Because most of the Fund's eligible Members have been receiving dental treatment on a regular basis, all that is generally needed to obtain the dental benefits the Plan provides is to have the dentist submit a claim to the Fund. Additionally, a Dental Claim Form can be obtained from the Fund office or may be printed off from the Fund’s web site (www.teamsterfunds.com). If, however, any of the following conditions exist, a Member or Dependent beneficiary may be required to be examined by a dentist selected by the Fund prior to beginning treatment:

1. Orthodontia (Braces) are anticipated (only for children between the ages of 10 and 18, inclusive).
2. You are randomly selected as a part of the Fund's Dental Audit Procedure.
3. Periodontal Care is anticipated.
4. Temporomandibular Joint Disorders.

C. Pharmacy Benefits

The Member or Dependent beneficiary's Prescription Drug Card should be used when filling prescriptions at a pharmacy. If the pharmacy does not accept the card, the prescription may still be filled or refilled. Simply file a completed "Direct Pay Card" with the Fund. The “Direct Pay Cards" are obtained from the Fund office for reimbursement by the Fund's Pharmacy Benefits Manager. Keep in mind that when using the "Direct Pay Cards" a Member's or Dependent beneficiary's out-of-pocket expense may be larger because the druggist is charging whatever the market will bear, but the Pharmacy Benefits Manager will only pay the Usual, Customary and Reasonable allowance for the prescription.

D. Vision Benefits

The Vision Form may be obtained from the Fund office or through the Fund’s website.

E. Death and AD&D Benefits

1. **Death or Dismemberment of the Participant** - Use Aetna's death benefit claim form. Complete the form and attach a certified copy of the death certificate as well as any other requested information. A copy of the claim form is available from the Fund office.

2. **Death of Spouse** - Use Aetna's death benefit claim form. Complete the form and attach a certified copy of the death certificate as well as any other requested information, including a copy of the marriage certificate.

3. **Death of a Child** - Use Aetna's death benefit claim form. Complete the form and attach a certified copy of the death certificate as well as any other requested information, as well as a copy of the child's birth certificate or other documents conferring parental rights to you under applicable law (e.g., a court order confirming an adoption of a child).

4. **For Member Total Disability Extended Death Benefits** – There is a special form that may be obtained only from the Fund office. This form must be completed yearly in order to qualify for coverage.

F. Weekly Disability Benefits

Please complete the Fund's disability benefit claim form. Be very certain to have the treating doctor complete his or her section in full, excluding his or her charges for services (the doctor's charges must be submitted on a separate medical claim form). The covered Employer must also complete the Company Statement section on the back of the claim form.

G. General Instructions for Completing Claim Forms

Claim forms may be obtained from the Fund office or through the Fund's web site (www.teamsterfunds.com). A separate claim form for each Family Member submitting a claim for benefits is required. Likewise, a separate claim form should be used for each Provider of Service. Each charge submitted should be checked and any errors reported to the Fund immediately.

NOTE: It is important to be careful completing claim forms. Make sure each appropriate section is completed in full. A great deal of the delay in processing a claim is the result of the Fund having to return claims to busy physicians or members for missing information. Be particularly accurate when writing names, dates of birth, social security numbers, accident information, etc.

If the payment is to be made directly to the Provider of Service, sign the appropriate "Assignment of Benefits Statement" contained on the claim form. If payment is to be made to a Member or Dependent beneficiary, please attach an original, itemized bill (not a copy) on the physician's or hospital's stationary to the claim form, along with a paid receipt to verify charges and payment. The physician should provide a detailed bill listing the following: diagnosis, dates of treatment, treatment performed, and charges for each treatment.

II. HOW SOON SHOULD YOU FILE YOUR CLAIM?

For all claims, written proof of loss or claim must be furnished to the Fund within ninety (90) days after the date of such loss or claim. Failure to furnish said proof within such time shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time; provided, however, that the Fund's liability position has not been prejudiced by the late filing.

All benefits provided by the Fund will be paid promptly upon receipt of a qualifying proof of loss. Any benefit payable for loss of the Member's life will be payable to the Member's designated beneficiary; other benefits will be payable to the Member, or the Member may assign these other benefits to the provider of service. In the event of an overpayment, either to you or to a "provider of service" on your behalf or on a Family Member's behalf, the Fund reserves the right to reduce subsequent benefit payments by the amount of such overpayment.

No claim will be honored or payable unless the claim is received in and filed with the Fund office prior to December 31 of the third year immediately following the year in which the loss was incurred or services were rendered. In addition, a medical claim form submitted outside of the deadlines required by an in-network healthcare provider's Member agreement with Aetna for the HMO or Blue Cross Blue Shield for the PPO will not be honored under the Plan. No action at law or in equity shall be brought to recover Fund benefits prior to the Member's or Dependent beneficiary's exhaustion of the claim appeal process set forth in this SPD, nor shall such action be brought at all unless brought prior to December 31 of the third year immediately following the year in which the loss was incurred.

III. CLAIM REVIEW / CLAIM APPEAL PROCEDURE

The Trustees maintain reasonable claim procedures for the Fund as required by law. They have therefore established the following claims review and appeal procedures in order to adjudicate claims for Fund benefits. The Trustees and the Fund's Administrator have the discretion and authority to interpret the terms of the Fund's plan documents, including without limitation this SPD, the Agreement and Declaration of Trust establishing this Fund and all restatements thereof, and the collective bargaining agreements establishing contributing Employer participation in the Fund, and to determine eligibility for Fund benefits to the greatest extent permitted by applicable law.

A. Precertification or Preauthorization Contact

A Claimant who wishes to precertify or preauthorize a form of medical treatment as required by this Plan should contact Horizon Blue Cross ("Horizon Blue Cross") at the telephone number found on the reverse side of the Member's identification card.

B. Authorized Representative

A Claimant for benefits under this Plan may appoint an authorized representative to act on the Claimant's behalf in pursuing a claim or an appeal from an adverse benefit determination. Any person who wishes to be recognized by the Plan as the authorized representative of a Claimant should contact the Fund office.

C. Filing of Claims

Any Member, former Member, dependent or beneficiary (designated or contingent) under the Plan ("Claimant"), may file a written claim for benefits with the Trustees through the Fund office, as described in Section I, above.

D. Notification on Denial of Claim

In the event of an adverse benefit determination, the Plan or Horizon Blue Cross will send the Claimant a written notification containing specific reasons for the adverse benefit determination. The written notification will contain specific reference to pertinent Plan provisions on which the adverse benefit determination is based. In addition, the written notification will contain a description of any additional material or information necessary for the Claimant to perfect the claim, as well as an explanation of why such material or information is necessary. Furthermore, the notification shall provide appropriate information as to the steps to be taken if the Claimant wishes to seek review of the adverse benefit determination.

The Fund or Horizon Blue Cross will provide notice of a benefit determination within the following time frames:

1. Urgent Care Claims

In the case of a claim involving urgent care, the Plan or Horizon Blue Cross shall notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant has failed to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan or Horizon Blue Cross shall notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of specific information necessary to

complete the claim. The Claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information.

The Plan or Horizon Blue Cross shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the specified information, or the end of the period afforded the Claimant to provide the specified additional information.

2. Concurrent Care Decision

If the Plan or Horizon Blue Cross has approved an ongoing course of treatment to be provided over a period of time or a number of treatments:

(a) Any reduction or termination by the Plan or Horizon Blue Cross of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan or Horizon Blue Cross shall notify the Claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and to obtain a determination on review that the adverse benefit determination before the benefit is reduced or terminated.

(b) Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments concerning a claim involving urgent care shall be decided as soon as possible, taking into account medical exigencies, and the Plan or Horizon Blue Cross shall notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

3. Pre-Service Claims

In the case of a pre-service claim, the Plan or Horizon Blue Cross shall notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan or Horizon Blue Cross. This period may be extended one time by the Plan or Horizon Blue Cross for up to 15 days, provided the Plan or Horizon Blue Cross both determine that such an extension is necessary due to matters beyond the control of the Plan or Horizon Blue Cross, and notifies the Claimant prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan or Horizon Blue Cross expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide this specified information.

4. Post-Service Claims

In the case of a post-service claim, the Plan shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan or Horizon Blue Cross for up to 15 days, provided that the Plan or Horizon Blue Cross determine that such an extension is necessary due to matters beyond the control of the Plan or Horizon Blue Cross and notifies the Claimant, prior to the expiration of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan or Horizon Blue Cross expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

5. Disability Claims

In the case of a claim for disability benefits under this Plan, the Plan shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan. This period may be extended by the Plan for up to 30 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring

the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Plan determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Claimant shall be afforded at least 45 days within which to provide the specified information.

6. Death and AD&D Claims

Because the Fund's death and AD&D benefits are a fully insured benefit, Aetna Life Insurance Company will notify the person seeking payment of such benefits of any adverse benefit determination and the process by which that person may seek a review of the determination under the Aetna policy.

G. Right of Review (Appeals)

1. Full and Fair Review

A Claimant who receives an adverse benefit determination with respect to any claim shall have the right to a full and fair review of that determination as required by law. For purposes of this Plan, an "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or 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 the determination of a Claimant's eligibility to participate in the Plan, and including a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review as well as a failure to cover an item or service for which benefits are otherwise provided because the service is determined to be experimental or investigational or not medically necessary or appropriate.

2. Time Frame for Seeking Review of an Adverse Benefit Determination

A Claimant may request review of an adverse benefit determination before the Fund's Claim Review Committee within 180 days of the Claimant's receipt of notification of that determination. Such a review should be initiated in writing, addressed to the Fund office.

3. Rules Applicable to a Review of an Adverse Benefit Determination

The following procedures shall apply to any review sought by a Claimant concerning an adverse benefit determination under this Plan:

a. The Claimant shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits.

b. The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits. A document, record or other information is relevant to a claim if: it was relied upon in making the benefit determination; submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; or demonstrates compliance with the administrative process and safeguards required herein or by applicable law.

c. The review of the adverse benefit determination shall take into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

d. The review shall not give deference to the initial adverse benefit determination and will be conducted by an appropriate fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is subject to the appeal nor the subordinate of any such individual.

e. If the adverse benefit determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, then the appropriate Plan fiduciary shall consult with a health care professional who has the appropriate training and experience in the relevant field.

f. The review process shall identify the medical or vocational expert, if any, whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

g. If a health care professional was consulted in connection with the adverse benefit determination, that person shall not be consulted in connection with the review of the adverse benefit determination.

h. In the case of a claim involving urgent care, there shall be provided an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant, and all necessary information, including the Plan's adverse benefit determination on review, shall be transmitted between the Plan or Horizon Blue Cross and the Claimant or Claimant's authorized representative by telephone, facsimile or other available similarly expeditious methods.

4. Right to Hearing Before Trustees' Appeals Committee

In the event that a Claimant is not satisfied with the outcome of its initial appeal of an adverse benefit determination before the Claim Review Committee, the Claimant may file a second-level appeal with the Trustees' Appeal Committee within 90 days of the denial of the initial appeal of the adverse benefit determination. The Trustees' Appeal Committee consists of at least two (2) Trustees designated by the Plan's Board of Trustees. A Claimant or Claimant's authorized representative may appear before this committee to present any evidence or argument in support of the claim review.

5. Content of Claim Review Determination

Each claim review determination shall be signed by the Fund's Administrator at the Claim Review Committee level, and by at least the two (2) Trustee members of the Appeal Committee authorized by the full Board of Trustees to resolve such claim review at the second level. The content of each determination will include: the specific reason or reasons for the adverse benefit determination; reference to the specific Plan provision on which the adverse benefit determination is based; a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits; and after the second level appeal a statement regarding whether the Claimant has exhausted his or her administrative remedies under the terms of this Plan, as well as any other information required by law.

6. Time Frames for Claim Review Determination

The following time frames shall apply to any rulings upon a requested claim review:

a. Urgent Care Claims. In the case of a claim involving urgent care, the Plan shall notify the Claimant, in accordance with Paragraph e of this section, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan.

b. Pre-Service Claims. In the case of a pre-service claim, the Plan shall notify the Claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 30 days after receipt by the Plan of the Claimant's request for review of the adverse benefit determination period.

c. Post-Service Claims. In the case of a post-service claim reviewed by the Trustees' Appeal Committee, the ruling on the claim review shall not be made later than the date of the Trustees' Meeting that immediately follows the Plan's receipt of the request for review, unless the request for review was filed within 30 days preceding the date of such Meeting. In such a case, a benefit determination may be made no later than the date of the second Trustees' Meeting following the Plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing) require a further extension for processing, a benefit determination shall be rendered not later than the third Trustees' Meeting following the Plan's receipt of the claim review. If such an extension of time for review is required because of special circumstances, the Plan shall notify the Claimant in writing of the extension, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The Plan shall notify the Claimant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

d. Disability Claims. In the case of a claim for disability benefits under this Plan reviewed by the Trustees' Appeal Committee, a ruling on the claim review shall be made not later than the date of the Meeting of the Trustees that immediately follows the Plan's receipt of the claim review, unless the claim review is filed within 30 days preceding the date of such Meeting. In such case, a benefit determination may be made by not later than the date of the second Meeting following the Plan's receipt of the request for review. If the special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third Meeting of the Trustees following the Plan's receipt of the request for review. If such an extension of time for a review is required because of special circumstances, the Plan shall notify the Claimant, in writing, of the extension, describing the special circumstances and the date by which the benefit determination shall be made prior to commencement of the extension period.

7. Furnishing Documents

In the case of an adverse benefit determination on review, the Plan shall provide such access to, and copies of, documents, records and other information as appropriate and required by law.

8. Definitions

The following definitions shall apply herein:

a. A claim involving "urgent care" means any claim for medical care or treatment with respect to which the application of the time period for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe paid that cannot be adequately managed without the care or treatment that is the subject of the claim.

b. "Pre-service claim" means any claim in which receipt of the benefit is conditioned, in whole or in part, upon precertification or preauthorization by the Plan.

c. The term "post-service claim" means any claim that is not a pre-service claim.

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GENERAL PROVISIONS AND DEFINITIONS

In addition to those terms defined in the Horizon Blue Cross PPO booklet, the following terms are defined as follows for purposes of this SPD.

Accidental Bodily Injury: For an injury to be considered an accident, the injury must have resulted from some external, violent and unforeseen happening.

Actual Charges: Means covered charges up to the Usual, Customary and Reasonable charges as defined in this Section, and never to exceed the payment the provider of service accepted as payment in full from any other source.

Assignment: The Member or his/her Spouse have the right to authorize the Fund to pay a Family Member's benefits directly to the physician or hospital who provided the Family Member with covered care and treatment. Except for this, however, you may not assign, alienate, anticipate or commute any benefits which a Family Member is entitled to receive from the Plan and, further, except as may be prescribed by law, none of your benefits shall be subject to any attachments or garnishments of or for your debts and/or contracts, etc., except for recovery of overpayments made on a Family Member's behalf by the Fund, as described under the HOW SOON SHOULD YOU FILE YOU CLAIM paragraph in the How To File a Claim section of this Booklet.

Automobile Insurance: Where an injury is caused by an accident that is covered by a State-required Automobile Insurance Law, the coverage under this Plan is secondary and the automobile insurance or Assigned Claims Plan is responsible to pay the covered charges for that injury first. The Plan will then cover the balance of the covered charges that were not covered by the automobile insurance, up to the maximum benefit level set forth in the applicable summary of benefits schedule.

Special additional exclusions apply in the case of No-Fault insurance policies that are governed by the New Jersey No-Fault Law, as amended by the New Jersey Insurance Freedom of Choice and Cost Containment Act. Participants, dependents and beneficiaries who are injured in the course of an automobile accident and who are also covered by an automobile insurance policy governed by the New Jersey No-Fault Law, as amended by the New Jersey Automobile Insurance Freedom of Choice and Cost Containment Act, may only be reimbursed under the Plan by the Fund up to a maximum of $1,000 per accident for Covered Expenses and, in the case of an eligible Member, only up to a Weekly Disability maximum of $62.50 per week up to the Plan maximum of twenty-six (26) weeks.

Benefit Period: Benefit Period shall mean the Plan Year which begins on January 1 and ends on December 31 of each year.

Claim Forms: The Fund, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such are not furnished within 30 days after the giving of notice, the claimant shall be deemed to have complied with the requirements of the Fund for submitting proof.

Claim Review Procedure: See " **HOW TO FILE A CLAIM FOR FUND BENEFITS AND APPEAL A DENIAL OF A CLAIM**" in this Booklet.

Collective Bargaining Agreement: The contract between a local union and a Contributing Employer through which the Employer is obligated to make contributions to the Fund on behalf of the employees covered by that Collective Bargaining Agreement.

Contributing Employer: An Employer whose signed Collective Bargaining Agreement requires the Employer to make contributions to the Fund on behalf of the employees covered by the terms of that Collective Bargaining Agreement.

Coordination of Benefits (C.O.B.): The Teamsters Health and Welfare Fund's Plan provides for Coordination of Benefits. This means that should a Family Member be entitled to any medical, dental, vision, disability or pharmacy benefits from another source, benefits under this Plan may be reduced to an amount, which together with all such other coverage under any other plan or policy, will not exceed 100% of any Usual, Customary and Reasonable item of expense covered under this Plan or any other such plan. The Fund has special rules for coordinating benefits with respect to automobile insurance. These rules are explained under the heading "Automobile Insurance" which is defined earlier in this section. In all other cases in which a Family Member, on whose behalf a claim is submitted, is covered under one or more group plans for health benefits in addition to the Fund's Plan, benefits will

be coordinated so that the Member may receive up to 100% of the Reasonable and Customary Charges in accordance with the following priorities of payment:

If the other plan providing benefits for a person covered under the Fund's Plan does not have a coordination of benefits or duplication of benefits provision, benefits payable for covered expenses under the other plan will be paid in full before any benefits are paid by the Fund's Plan.

If the other plan providing benefits for a person covered under the Fund's Plan does have a coordination or non-duplication provision, the following rules will apply for determining whether the Fund or the other plan will provide primary coverage. For the purposes of these rules, the plan which provides "primary coverage" shall be obligated to provide benefits to the fullest extent of its coverage before any other plan is obligated to cover the benefits in question. The plan which provides "secondary coverage" shall not be obligated to provide benefits until the "primary coverage" is exhausted.

Dependent Spouses: In each case, the other plan will provide primary coverage for the dependent spouse (who may also be referred to as a "Dependent beneficiary"), and the Fund will provide secondary coverage for the dependent spouse. A spouse who (i) works full-time (defined as regularly scheduled to work 32 or more hours per week), and (ii) who is eligible to participate in group health coverage sponsored by his/her Employer must enroll in that coverage except if the spouse must pay 100% of the premium for such coverage. If the spouse is required to enroll in such coverage, but does not, the Fund will provide secondary coverage and only to the extent as if the other coverage was in effect as of the date services were rendered to the patient/spouse.

Dependent Children:

If a dependent child (alternatively referred to as a "Dependent beneficiary") is gainfully employed and is covered by another plan as a result of that employment, then no coverage is available under the Fund's plan for such dependent child.

If the paragraph above is not applicable and the Member and the child's other parent are married to each other and not separated, then the "birthday rule" shall apply. Under the birthday rule, the Fund will provide primary coverage if the Member’s birthday occurs before the spouse's birthday during the calendar year. For example, if the Member was born in June and the spouse in September, then the Fund will provide primary coverage and the spouse's plan will provide secondary coverage. On the other hand, if the spouse's birthday occurred earlier in the calendar year than the Member's birthday, then the spouse's plan will provide primary coverage and the Fund will provide secondary coverage. If the Member and the spouse have the same birthday in the calendar year, then the plan which covered the individual for whom the claim is made for the longer period of time shall be primary.

If the Member and the child's other parent are either separated or divorced from each other, then the following rules shall apply.

If there is a court order which establishes or apportions the parents' respective obligations to provide for the medical, dental or other health care expenses of any such child, then benefits will be apportioned in accordance with the provisions of the court order, provided that such court order cannot grant benefits which are not otherwise provided by the Fund.

In the absence of such a court order establishing such financial responsibility, the following shall be the order of payment of benefits for such dependent child:

Parents Separated or Divorced - Not Remarried	Parents Separated or Divorced and Remarried
1. Plan covering Parent with Custody	1. Plan covering Parent with Custody
2. Plan covering Parent without Custody	2. Plan covering Step-Parent with Custody
	3. Plan covering Parent without Custody

The Fund's Plan will not provide any benefit if the person for whom the claim is made is a pensioner, or the dependent of a pensioner who is gainfully employed and his employer provides him with health insurance or the person for whom the claim is made is not a Member, or an eligible dependent of a Member.

If the rules set forth above do not establish the order of benefit payment, the plan which covered the person for whom the claim is made for the longer period of time shall be considered the primary source of benefits.

***Medicare Coverage*:** For Covered Expenses incurred by Members and/or Dependents age 65 through 69 years, except for dependents age 65 through 69 of Members over age 69, the coverage provided by the Fund is primary. In those cases where the Member is actively at work, the Fund's coverage is primary. In all other situations, Medicare coverage is primary and the Fund is secondary.

Under no circumstances will the Fund pay any benefits as the primary plan when a Member or the dependent of a Member has elected to make the Fund the primary plan by waving coverage under any other plan. This provision shall be effective regardless of whether the dependent waived enrollment in such other plan (when required to enroll in circumstances described in paragraph g. below) or, if enrolled, sought or secured services outside of the required network of providers of such other plan.

If a group plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed a benefit payment.

Benefits otherwise payable under the Fund's Plan shall be reduced in accordance with the above priorities of payment to the extent necessary so that the sum of such reduced benefits payable under all group plans shall not exceed the total of the Usual, Customary and Reasonable charges for the service provided.

If a dependent spouse is employed full time (defined as being regularly scheduled to work 32 or more hours each week) and is eligible to enjoy group coverage through his/her employer at less than 100% of the cost to him/her, the spouse must enroll for such coverage (single coverage only). Furthermore, if such coverage exists for the spouse, the spouse may not waive coverage in lieu of a salary increase or other financial remuneration.

If the Member's spouse or other eligible dependents are subject to coordination of benefits, the Fund employs a "C.O.B. Bank" that will reimburse the member for certain co-payments and other out of pocket expenses incurred by the spouse or other eligible dependents in receiving medical treatment. In order to be eligible for reimbursement, the charges must be supported by a receipt and relate to services that were covered under the spouse's health plan. Additional information regarding the C.O.B. bank is available by calling the Fund's office.

Counseling: Counseling is not a covered benefit unless it is performed by a Physician as defined in this Booklet. In addition, the counseling must be related to the patient being treated for a mental illness and/or functional nervous disorder, drug abuse and alcoholism. The counseling must also be performed in a non-group setting, unless the other Members are Family Members, in which case the Fund would still only provide a single individual benefit allowance per session.

Covered Expenses: Only actual charges for an item or service which is specifically listed as a covered benefit under a provision of the Plan which is covered by your specific Summary of Benefits Schedule which accompanies this Booklet.

Deductible: A specified amount of Covered Expenses for the Covered Services that is incurred by the Covered Person before the Fund will assume any liability.

Dependent: (See Eligibility Provisions in the front of this Booklet.)

Family Member: (See Eligibility Provisions in the front of this Booklet.)

Fraud: No benefits under this Plan will be paid if the person on whose account, or by whom the benefit is claimed, or the provider of service attempts to perpetrate a fraud upon or misrepresents a fact to the Fund with respect to any such claim. In the case of such conduct, the Board of Trustees, may, in its sole and exclusive discretion, pay no further benefits to the Member, dependent or beneficiary involved as to the particular claim or as to any other claims arising during a period of not more than one year after the discovery of such fraud, attempted fraud or misrepresentation. The Fund shall have the right to fully recover any amounts, with interest, improperly paid by the Fund by reason of fraud, attempted fraud or misrepresentation of fact by a Member, dependent, beneficiary or provider of service and to pursue all other legal remedies. The Board of Trustees shall have the right to finally determine whether or not a fraud has been attempted or committed upon the Fund or if a misrepresentation of fact has been made, and its decision shall be final, conclusive and binding upon all persons.

Fund: The Teamsters Health and Welfare Fund of Philadelphia and Vicinity.

Group Therapy: Is not covered unless the only other Members in the "group" are other Family Members. In addition the therapy must be performed by a physician as defined in this Booklet and be related to treatment of a mental illness, a functional nervous disorder, drug abuse or alcoholism. Regardless of the number of Family Members participating in the therapy session, only a single individual allowance will be made per session.

Hospital(s): An acute care institution which meets the following requirements:

Is licensed as a **Hospital** by the State in which it is located, and the primary function of the institution is providing inpatient medical care and treatment through medical diagnostic and major surgical facilities on its premises under the supervision of a staff of physicians, and with 24 hour a day nursing service, and

Is not owned or operated by the United States Government or by a State (or political subdivision thereof) unless there is an unconditional requirement that persons receiving care must pay for such care.

However, "**Hospital**" does not include a Nursing Home or an institution, or part of one, used primarily as a facility for convalescence, rehabilitation, treatment of mental illness or functional nervous disorders, a place for the aged, a rest home, a place for alcoholics, or place for drug addicts.

Inpatient: An individual who, while confined in a Hospital or Special Care Facility, is assigned to a bed in any department of the institution other than its outpatient department and for whom a charge for room and board is made.

Legend Drugs: Drugs, biologicals, and compounded prescriptions which, by Federal Law can be dispensed only pursuant to a prescription, and are required to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription."

Maternity Coverage: Maternity coverage under the Plan available to female members and the female spouses of members. Under federal law, the Fund may not restrict benefits for any hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Fund may not, under federal law, require that a provider obtain authorization from the Fund for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medically Appropriate or Medically Necessary: Means services or supplies that are:

1. appropriate for the symptoms and diagnosis or treatment of the Family Member's condition, illness, disease or injury; and

2. required for the diagnosis, or the direct care and treatment of the Family Member's condition, illness, disease or injury; and

3. in accordance with standards of good medical practice as generally recognized and accepted by the medical community; and

4. not primarily for the convenience of either the Family Member's family or a provider of medical services; and

5. the most efficient and economical supply or level of service that can safely be provided to the Family Member. When applied to hospitalization, this further means that the Family Member requires acute care as a bed patient due to the nature of the services rendered or the Family Member's conditions, and the Family Member cannot receive safe and adequate care in some other setting without adversely affecting the Family Member's condition or quality of medical care.

Medicare: To the extent permitted by law, Medicare benefits will be taken into account for any Member or Dependent while they are eligible to apply for Medicare, whether or not they actually apply. The Fund will determine a Family Member's benefit allowance, if any, based upon the applicable Medicare statutes and regulations.

Member (or Eligible Member or Participant): An individual who has satisfied the eligibility requirements based on contributions made on his/her behalf by his Employer to the Fund and has qualified for the benefit program. Members include the

following types of employees: (1) an employee covered by a collective bargaining agreement or participation agreement that requires his/her employer to contribute to the Fund on his/her behalf, and/or (2) an employee of a Labor Union or trade association which contributes to the Fund on his/her behalf.

The masculine pronoun whenever used shall include the feminine pronoun and the singular shall include the plural where appropriate.

Participating Local Union: A union with whom any of the contributing Employers have entered into a signed Collective Bargaining Agreement, as a requirement of which, the Employer is obligated to make contributions to the Fund on behalf of the employees covered by that Collective Bargaining Agreement.

Physical Examination: The Fund reserves the right to examine at its own expense and as often as necessary, any person whose injury or sickness is the basis of a claim and, in the case of any death claim, to have an autopsy made.

Physician: Means a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a doctor of chiropractic medicine (D.C.), a doctor of dental surgery (D.D.S.), a doctor of dental medicine (D.M.D.), a doctor of podiatric medicine (D.P.M.), and optometrist (O.D.). A clinical psychologist (Ph.D., M.S., or M.A. or L.S.W.), when providing treatment for mental illness or functional nervous disorders, shall also be considered a physician.

Plan: Means this Booklet, the Horizon PPO booklet appended hereto, and any modifications thereto published by the Teamsters Health and Welfare Fund of Philadelphia and Vicinity duly adopted by the Fund's Board of Trustees in accordance with their authority set forth in the Agreement and Declaration of Trust establishing the Fund. Additionally, the Trustees of the Fund, by unanimous action, may terminate, suspend, withdraw, amend or modify the benefits available under the Fund, in whole or in part, at any time and without any prior notice. Any such termination, suspension, withdrawal, amendment or modification of benefits shall not require the consent of any Employer, union, Member or Dependent, nor shall such action require individual notice to any such person or organization .

Prescription: A written order of a physician or where permitted by law, an oral order of a physician, for legend drugs to the extent that such order is within the scope of such physician's license.

Special Care Facility: An institute other than a Hospital (as defined in this Booklet) which:

1. specializes in physical rehabilitation of injured or sick patients, or
2. specializes in the diagnosis and treatment of mental illness or functional nervous disorders, or
3. specializes in the diagnosis and treatment of alcoholism, drug addiction or mental and nervous disorders.
4. In addition, to qualify as a **Special Care Facility**, an institution must be:
5. legally licensed to give medical treatment, and
6. operated under the supervision of a physician, and
7. offer nursing service by registered graduated nurses or licensed practical nurses.

However, the term "**Special Care Facility**" does not include an institution or part of one that is used mainly as a facility for rest, convalescence, or for the aged.

Spouse: Means either your lawful wife or your lawful husband; however, separated spouses are not covered. A married couple is "separated" if they are living separate and apart with an intent to terminate or abandon the marital relationship.

Summary of Benefits Schedule: This is the various sections that accompany this Booklet that contain the actual allowances for your various benefits. This includes a partial listing of covered dental allowances. You may write the or call the Fund office to learn the allowance of any covered procedure not listed, or you may check the Fund's website (www.teamsterfunds.com). The maximum allowance may not exceed the fee actually charged for the procedure.

Totally Disabled:

For Member: You are prevented from engaging in your customary occupation solely because of injury or disease and are performing no work of any kind for pay or profit.

For Dependent: Your dependent is prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health solely because of injury or disease.

Usual, Customary and Reasonable Allowance (or "UCR"): The benefit allowance for a procedure or service performed by a Physician or other medical service provider, taking into account the most consistent charge by an individual physician or provider of service to patients for a given service, the range of usual charges for a given service billed by most physicians or providers of service with similar training and experience within a given area, and the complexity of treatment of the particular case.

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IMPORTANT INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT ("ERISA")

Plan Year: The Plan Year starts on January 1 and ends on December 31, and consists of an entire calendar year for the purposes of accounting and preparing the reporting and disclosure information which must be submitted to the United States Department of Labor and other regulatory bodies.

Plan Funding: The Plan is funded through Employer contributions, the amount of which is specified in the Collective Bargaining Agreement between your Employer and your Local Union. The Plan is maintained by more than ten Collective Bargaining Agreements which are between, among others, the Teamsters Locals 107, 115, 312, 326, 331, 384, 463, 500, 623, 628, 676 and 929 and various Employer associations that have entered into labor contracts with these Local Unions. Other groups participate in the benefit program by reason of Participation Agreements. Applicable collective bargaining agreements may be reviewed at the Fund office.

Benefits provided under the Plan, other than death benefits, are self-insured and paid directly from the corpus of the Trust Fund.

Upon written request, the Administrator will furnish you with information as to whether a particular Employer participates in the Plan and, if so, its address.

Types of Benefits: This Plan provides comprehensive Hospitalization, Surgical, Medical, Dental, Vision, Death and Dismemberment, Short-term Weekly Disability and Prescription Drug Benefits. Please refer to the Table of Contents and the Summary of Benefits Schedule for more information concerning the benefits provided under this Plan. The Trustees retain the right to amend or terminate the Plan or Plan Benefits set forth in this booklet to the fullest extent provided by law.

Your Rights Under ERISA: As a Member in the Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, provided that all Plan Members shall be entitled to:

- Receive Information About Your 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, if any, 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, insurance contracts, if any, 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 Member with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- A reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up; to 24 months after losing coverage. Without evidence of creditable coverage, you may be subjected to a preexisting condition exclusion for 12 months (18 months for late

enrollees) after your enrollment date in your coverage. The Fund's Plan does not contain any exclusions for preexisting conditions.

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

Enforcing Your Rights: If your claim for a benefit under this Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these fees. If you lose, the court may order you to pay these costs and fees. For example: If it finds your claim is frivolous.

Assistance with Your Questions: If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your 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, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

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HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. <u>USE AND DISCLOSURE OF HEALTH INFORMATION</u>

The Teamsters Health & Welfare Fund of Philadelphia and Vicinity (the "Fund") may use your health information, that is, information that constitutes "protected health information" as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Fund has established a policy to guard against unnecessary disclosure of your health information. Please note that, under the Privacy Rule, "protected health information" does not include information relating to weekly disability or life insurance benefits.

IN ADDITION TO OTHER USES AND DISCLOSURES PERMITTED UNDER HIPAA, THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

A. <u>To Make or Obtain Payment</u>. The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other trust funds, health plans or providers, for the care you receive. For example, the Fund may provide information regarding your coverage or health care treatment to other the Funds to coordinate payment of benefits.

B. <u>To Conduct Health Care Operations</u>. The Fund may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Member Service activities relating to claim eligibility and payment. Benefit eligibility of a family member may be disclosed to the Member or spouse (or, in the case of a non-mentally handicapped dependent child over the age of 18, to that dependent child). Limited information (such as whether a claim has been received or paid) regarding your claims may be disclosed, upon appropriate authentication, to your spouse, unless you advise us that no information should be released to your spouse except upon an express written authorization. Claims information relating to dependent children under the age of 18 may be disclosed to the parent or legal guardian of that child. Claims information relating to covered dependents over the age of 18 may be disclosed only to that dependent, unless the dependent authorizes the disclosure of claims information to someone else, including the parent or legal guardian of that dependent. Claims information relating to a mentally handicapped dependent child over the age of 18 may be disclosed to the parent or legal guardian of that child.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.

- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Fund, including customer service and resolution of internal grievances.

For example, The Fund may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

C. **For Treatment Alternatives**. The Fund may use and disclose your health information to Fund consultants to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

D. **For Distribution of Health-Related Benefits and Services.** The Fund may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

E. **For Disclosure to the Plan Sponsor.** The Fund may disclose your health information to the plan sponsor (the Fund's Board of Trustees) for plan administration functions performed by the plan sponsor on behalf of the Fund. The Fund also may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from other the Funds or modify, amend or terminate the plan.

F. **When Legally Required.** The Fund will disclose your health information when it is required to do so by any federal, state or local law.

G. **To Conduct Health Oversight Activities**. The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Fund, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

H. **In Connection With Judicial and Administrative Proceedings**. As permitted or required by state law, the Fund may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Fund makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

I. **For Law Enforcement Purposes**. As permitted or required by state law, the Fund may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

J. **In the Event of a Serious Threat to Health or Safety**. The Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Fund, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

K. **For Specified Government Functions**. In certain circumstances, federal regulations require the Fund use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

L. **For Worker's Compensation**. The Fund may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

II. AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Fund will not disclose your health information other than upon your written authorization. This includes uses and disclosures of protected health information relating to psychotherapy, for marketing purposes, and/or sales of protected health information. An authorization must contain certain language and, for that reason, the Fund has developed an appropriate form that is available in the Fund office or on the Fund's web site. Such authorizations are limited by the event (such as a claim) and by time. Blanket authorizations for general disclosures are not permitted under HIPAA's Privacy Rule. If you authorize the Fund to use or disclose your health information, you may revoke that authorization in writing at any time.

III. YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that The Fund maintains:

A. Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund is not required to agree to your request, unless the disclosure is for the purpose of carrying out payment or health care operations, is not otherwise required by law, and the protected health information pertains solely to a health care item or service for which payment in full has been made by someone or something other than the Fund. If you wish to make a request for restrictions, please contact the Fund's Privacy Officer whose name and address appears at the end of this Notice.

B. Right to Receive Confidential Communications. You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Fund only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice. The Fund will attempt to honor your reasonable requests for confidential communications.

C. Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be signed, made in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice and must include identify the person designated by you to inspect your protected health information and where to send the copy of protected health information. If you request a copy of your health information, the Fund may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

D. Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice. The Fund may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.

E. Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Fund for any reason other than for (1) treatment, payment or health care operations, (2) disclosures made under circumstances described in this Notice, or (3) disclosures which you authorized. The request must be made in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.

F. Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy,

please contact Fund's Privacy Officer whose name and address appears at the end of this Notice. ***You also may obtain a copy of the current version of the Fund's Notice at its web site, www.teamsterfunds.com.***

IV. DUTIES OF THE FUND

The Fund is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice of its duties and privacy practices, and to notify affected individuals following a breach of unsecured protected health information. The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to Fund's Privacy Officer whose name and address appears at the end of this Notice. The Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

V. CONTACT PERSON

The Fund has designated William J. Einhorn, the Fund's Administrator as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at the following:

William J. Einhorn, Privacy Officer
Teamsters Health & Welfare Fund of Philadelphia and Vicinity
6981 N. Park Drive, Suite 400
Pennsauken, NJ 08109
856-382-2470
856-382-2401 (fax)

VI. EFFECTIVE DATE

This Notice is effective March 26, 2013.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE PRIVACY OFFICER IDENTIFIED ABOVE.

APPENDIX A

THE PREFERRED PROVIDER ORGANIZATION

HEALTH BENEFITS PROGRAM

Horizon Blue Cross/Blue Shield of New Jersey
(Hereafter called "the Claims Administrator")

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INTRODUCTION

This booklet has been prepared so that you may become acquainted with the Preferred Provider organization health care plan offered by your Fund. Coverage under your Fund's plan is available to active Members who are eligible for the Coverage and enrolled in it. The Preferred Provider Organization health care coverage described in this booklet is subject to the terms and conditions of the Fund coverage administered by Horizon Blue Cross/Blue Shield of New Jersey.

Benefits will not be available for services to a greater extent or for a longer period than is Medically Appropriate/Medically Necessary, as determined by the Claims Administrator. The amount of benefits for any Covered Service will not exceed the amount charged by the health care provider, and will not be greater than any maximum amount or limit described or referred to in this booklet.

SPECIAL NOTE FOR PART-TIME EMPLOYEES:

If you are or become a part-time employee, as determined by the Health & Welfare Fund, the benefits described in this booklet are limited to you, the employee. Contact the Fund if you are unsure as to your status as a fulltime or part-time employee. NO COVERAGE IS PROVIDED FOR THE SPOUSE OR DEPENDENT CHILDREN OF A PART-TIME EMPLOYEE.

IMPORTANT NOTICES:

REGARDING EXPERIMENTAL/INVESTIGATIONAL TREATMENT:

The Claims Administrator does not cover treatment it determines to be experimental/ Investigational in nature because that treatment is not accepted by the general medical community for the condition being treated or not approved as required by federal or governmental agencies. However, the Claims Administrator acknowledges that situations exist when a Covered Person and his or her Physician agree to utilize Experimental/Investigational treatment. If a Covered Person receives Experimental/ Investigational treatment, the Covered Person shall be responsible for the cost of the treatment. A Covered Person or his or her Physician should contact the Claims Administrator to determine whether a treatment is considered Experimental/ Investigational. The term "Experimental/Investigational" is defined in the ***Defined Terms*** section.

REGARDING TREATMENT WHICH IS NOT MEDICALLY APPROPRIATE/MEDICALLY NECESSARY:

The Claims Administrator only covers treatment which it determines Medically Appropriate/ Medically Necessary. A Member/Contracting Provider accepts the Claims Administrator’s decision and contractually is not permitted to bill the Covered Person for treatment which the Claims Administrator determines is not Medically Appropriate/Medically Necessary unless the Member/Contracting Provider specifically advises the Covered Person in writing, and the Covered Person agrees in writing that such services are not covered by the Claims Administrator, and that the Covered Person will be financially responsible for such services. A Non-Member/Non-Contracting Provider, however, is not obligated to accept the Claims Administrator's determination and the Covered Person may not be reimbursed for treatment which the Claims Administrator determines is not Medically Appropriate/Medically Necessary. The Covered Person is responsible for these charges when treatment is received by a Non-Member/Non-Contracting Provider. You can avoid these charges simply by choosing a Member/Contracting Provider for your care. The term "Medically Appropriate/Medically Necessary" is defined in the Defined Terms section.

REGARDING TREATMENT FOR COSMETIC PURPOSES:

The Claims Administrator does not cover treatment which it determines is for cosmetic purposes because it is not necessitated as part of the Medically Appropriate/Medically Necessary treatment of an illness, injury or congenital birth defect. However, the Claims Administrator acknowledges that situations exist when a Covered Person and his or her Physician decide to pursue a course of treatment for cosmetic purposes. In such cases, the Covered Person is responsible for the cost of the treatment. A Covered Person or his or her Physician should contact the Claims Administrator to determine whether treatment is for cosmetic purposes. The exclusion for services and operations for cosmetic purposes is detailed in the ***What Is Not Covered*** section.

REGARDING COVERAGE FOR EMERGING TECHNOLOGY:

While the Claims Administrator does not cover treatment it determines to be Experimental/Investigational, it routinely performs technology assessments in order to determine when new treatment modalities are safe and effective. A technology assessment is the review and evaluation of available clinical and scientific information from expert sources. These sources include but are not limited to articles published by governmental agencies, national peer review journals, national experts, clinical trials, and manufacturer's literature. The Claims Administrator uses the technology assessment process to assure that new drugs, procedures or devices ("emerging technology") are safe and effective before approving them as Covered Services. When new technology becomes available or at the request of a practitioner or
Covered Person, the Claims Administrator researches all scientific information available from these expert sources. Following this analysis, the Claims Administrator makes a decision about when a new drug, procedure or device has been proven to be safe and effective and uses this information to determine when an item becomes a Covered Service for the condition being treated or not approved as required by federal or governmental agencies. A Covered Person or his or her Provider should contact the Claims Administrator to determine whether a proposed treatment is considered "emerging technology".

REGARDING USE OF NON-PREFERRED PROVIDERS:

To receive the maximum benefits available under this program, the Covered Person must obtain Covered Services from Preferred Providers that participate in the PPO Network or in the Blue Card PPO Program. While this PPO program has an extensive network, it may not contain every provider that a Covered Person needs. The Covered Person may obtain Covered Services from Participating Professional Providers or Member Facility Providers (Participating Providers) who are not part of the PPO Network but have agreed to accept contracted rates as payment in full and will not balance bill. However, those services will be subject to Non-Preferred "Out-of-Network" Coinsurance and Deductibles. In addition, the PPO program allows a Covered Person to obtain Covered Services from Non-Preferred, Non-Participating Providers. If a Covered Person uses a Non-Preferred, Non-Participating Provider, the Covered Person will be reimbursed for Covered Services but will incur significantly higher out-of-pocket expenses including Deductibles, Coinsurance and the balance of the provider's bill. This is true whether a Non-Preferred, Non-Participating Provider is used by choice, for level of expertise, for convenience, for location, because of the nature of the services or based on the recommendation of a provider.

The Claims Administrator may approve Covered Services provided by a Non-Preferred Provider subject to Preferred "In-Network" cost-sharing, if such cost-sharing is applicable to the program (Copayments, Coinsurance and Deductibles), if the Covered Person has: (1) first sought and received care from a Preferred Provider in the same American Board of Medical Specialties (ABMS) recognized specialty as the Non-Preferred Provider requested; (2) been advised by the Preferred Provider that there are no Preferred Providers that can provide the requested Covered Services; and (3) obtained authorization from the Claims Administrator prior to receiving care. The Claims Administrator reserves the right to make the final determination whether there is a Preferred Provider that can provide the Covered Services. If the Claims Administrator approves the use of a Non-Preferred, Non-Participating Provider, the Covered Person will not be responsible for the difference between the provider's billed charges and the Claims Administrator's payment to the Provider. Applicable program terms including Medical Necessity/ Appropriateness and precertification will apply.

REMEMBER: Whenever a Provider suggests a new treatment option that may fall under the category of "Experimental/Investigational", "cosmetic", or "emerging technology", the Covered Person, or his or her Provider, should contact the Claims Administrator for a coverage determination. That way the Covered Person and the Provider will know in advance if the treatment will be covered by the Claims Administrator.

In the event the treatment is not covered by the Claims Administrator, the Covered Person can make an informed decision about whether to pursue alternative treatment options or be financially responsible for the non-covered service. For more information on when to contact the Claims Administrator for coverage determinations, please see the Precertification and Prenotification requirements in the *Managed Care* section.

DEFINED TERMS

The terms below have the following meaning when describing the benefits within this Booklet. They will be helpful to you in fully understanding your benefits.

ACCESSIBILITY – the extent to which a member of a Managed Care Organization can obtain from a Preferred Provider available Covered Services at the time they are needed. Accessibility to a Preferred Provider refers to both telephone access and ease of scheduling an appointment.

ACCIDENTAL INJURY – bodily injury which results from an accident directly and independently of all other causes.

ACCREDITED EDUCATIONAL INSTITUTION – a publicly or privately operated academic institution of higher learning which: (a) provides recognized course or courses of instruction and leads to the conference of a diploma, degree, or other recognized certification of completion at the conclusion of the course of study; and (b) is duly recognized and declared as such by the appropriate authority of the state in which such institution is located; provided, however, that in addition to any state recognition, the institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education. The definition may include, but is not limited to, colleges and universities, and technical or specialized schools.

ALTERNATIVE THERAPIES/COMPLEMENTARY MEDICINE – Complementary and alternative medicine, as defined by the National Institute of Health's National Center for Complementary and Alternative Medicine (NCCAM), is a group of diverse medical and health care systems, practices, and products, currently not considered to be part of conventional medicine. NCCAM categorizes complementary medicine and alternative therapies into the following five classifications: (a) alternative medical systems (e.g., homeopathy, naturopathy, Ayurveda, traditional Chinese medicine); (b) mind-body interventions which include a variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms (e.g., meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance); (c) biologically based therapies using natural substances, such as herbs, foods, vitamins or nutritional supplements to prevent and treat illness (e.g., diets, macrobiotics, megavitamin therapy); (d) manipulative and bodybased methods (e.g., massage, equestrian/hippotherapy); and (e) energy therapies, involving the use of energy fields. The energy therapies are of two types: (1) Biofield therapies - intended to affect energy fields that purportedly surround and penetrate the human body. This includes forms of energy therapy that manipulate biofields by applying pressure and/or manipulating the body by placing the hands in, or through, these fields. Examples include Qi Gong, Reiki, and therapeutic touch. (2) Bioelectromagnetic-based therapies involve the unconventional use of electromagnetic fields, such as pulsed fields, magnetic fields, or alternating-current or direct-current fields.

AMBULATORY SURGICAL FACILITY – a Facility Provider, with an organized staff of Physicians, which is licensed as required and which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health care, Inc., or by the Claims Administrator and which:

A. has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis;

B. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

C. does not provide Inpatient accommodations; and

D. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

ANCILLARY PROVIDER – an individual or entity that provides services, supplies or equipment (such as, but not limited to, Home Infusion Therapy services, Durable Medical Equipment and ambulance services), for which benefits are provided under the coverage.

ANESTHESIA – consists of the administration of regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

APPEAL – A request by a Covered Person, or the Covered Person's representative or Provider, acting on the Covered Person's behalf upon written consent, to change a previous decision made by the Claims Administrator.

A. Administrative Appeal – an appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding coverage terms such as contract exclusions and non-covered benefits. Administrative appeal may present issues related to Medical Necessity or Medical Appropriateness, but these are not the primary issues that affect the outcome of the appeal.

B. Medical Necessity Appeal – request for the Claims Administrator to change its decision, based primarily on Medical Necessity and Appropriateness, to deny or limit the provision of a Covered Service.

C. Expedited Appeal – a faster review of a Medical Necessity Appeal, conducted when the Claims Administrator determines that a delay in decision making would seriously jeopardize the Covered Person's life, health, or ability to regain maximum function.

APPLICANT AND MEMBER – you, the Member who applies for coverage under the Plan.

APPLICATION AND APPLICATION CARD – the request, either written or via electronic transfer, of the Applicant for coverage, set forth in a format approved by the Claims Administrator.

ATTENTION DEFICIT DISORDER – a disease characterized by developmentally inappropriate inattention, impulsiveness and hyperactivity.

BENEFIT PERIOD – the specified period of time as shown in the Schedule of Benefits during which charges for Covered Services must be Incurred in order to be eligible for payment by the Claims Administrator. A charge shall be considered Incurred on the date the service or supply was provided to a Covered Person.

BIRTH CENTER – a Facility Provider approved by the Claims Administrator which (1) is licensed as required in the state where it is situated, (2) is primarily organized and staffed to provide maternity care, and (3) is under the supervision of a Physician or a licensed certified nurse midwife.

CASE MANAGEMENT – Comprehensive Case Management programs serve individuals who have been diagnosed with a complex, catastrophic, or chronic illness or injury. The objectives of Case Management are to facilitate access by the Covered Person to ensure the efficient use of appropriate health care resources, link Covered Persons with appropriate health care or support services, assist Providers in coordinating prescribed services, monitor the quality of services delivered, and improve Covered Person outcomes. Case Management supports Covered Persons and Providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic or chronic illness and/or injury across various levels and sites of care.

CERTIFIED REGISTERED NURSE – a certified registered nurse anesthetist, certified registered nurse practitioner, certified entreostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the state Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility or by an anesthesiology group.

COINSURANCE – a type of cost-sharing in which the Covered Person assumes a percentage of the Covered Expense for Covered Services (such as 10 percent).

COMPLAINT – any expression of dissatisfaction, verbal or written, by a Covered Person.

COMPLICATIONS OF PREGNANCY –

(a) conditions requiring medical treatment prior or subsequent to the termination of pregnancy whose diagnoses are distinct from pregnancy but which are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, disease of the vascular, hemopoieatic, nervous, or endocrine systems, and similar medical and surgical conditions of comparable severity; but will not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy, not constituting a classifiable distinct complication of pregnancy; and

(b) hyperemesis gravidarum and pre-eclampsia requiring hospital confinement, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

(c) Conditions requiring medical treatment after the termination of pregnancy whose diagnoses are distinct from pregnancy but which are adversely affected by pregnancy or caused by pregnancy.

COPAYMENT – a type of cost-sharing in which the Covered Person pays a flat dollar amount each time a Covered Service is provided (such as a $15 or $25 Copayment per office visit). Copayments, if any, are identified in the Schedule of Benefits.

COVERED EXPENSE – refers to the basis on which a Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

(a) With respect to services rendered by providers with which your local Blue Cross and Blue Shield Plan has negotiated a special pricing arrangement, Covered Expense is the amount payable to the provider under the special pricing arrangement.

(b) (i) With respect to services rendered by Facility and Ancillary Providers with which your local Blue Cross and Blue Shield Plan has not negotiated a special pricing arrangement, Covered Expense is the lesser of the: (1) Provider's charges, (2) Medicare Allowable Payment, or (3) Reasonable and Customary Charge for the Covered Services.

(ii) With respect to services rendered by Professional Providers with which your local Blue Cross and Blue Shield Plan has not negotiated a special pricing arrangement, Covered Expense means the amount as determined by the Claims Administrator’s lowest network fee schedule that the Claims Administrator would have paid to a Preferred Professional Provider in the Claims Administrator’s local network for the same service, or the charge whichever is less.

COVERED PERSON – an enrolled Member or his Eligible Dependents who have satisfied the specifications of the Schedule of Eligibility. A Covered Person does not mean any person who is eligible for Medicare except as specifically stated in this booklet.

COVERED SERVICE – a service or supply specified in this booklet for which benefits will be provided by the Claims Administrator.

CUSTODIAL CARE (DOMICILIARY CARE) – provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications, which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

DAY REHABILITATION PROGRAM – is a level of Outpatient care consisting of four (4) to seven (7) hours of daily rehabilitative therapies and other medical services five (5) days per week. Therapies provided may include a combination of therapies, such as Physical Therapy, Occupational Therapy, and Speech Therapy, as otherwise defined in this Plan and other medical services such as nursing services, psychological therapy and Case Management services. Day Rehabilitation sessions also include a combination of one-to-one and group therapy. The Covered Person returns home each evening and for the entire weekend.

DEDUCTIBLE – a specified amount of Covered Expenses for the Covered Services that is incurred by the Covered Person before the Claims Administrator will assume any liability.

DURABLE MEDICAL EQUIPMENT – is equipment which meets the following criteria:

A. it is durable and can withstand repeated use;

B. it is medical equipment, meaning it is primarily and customarily used to serve a medical purpose;

C. it generally is not useful to a person in the absence of an illness or injury; and

D. it is appropriate for use in the home.

Durable Medical Equipment includes, but is not limited to: diabetic supplies, canes, crutches, walkers, commode chairs, home oxygen equipment, hospital beds, traction equipment and wheelchairs.

EFFECTIVE DATE – according to the Eligibility Section, the date on which coverage for a Covered Person begins under your Preferred Provider Organization Plan. All coverage begins at 12:01 a.m. on the date reflected on the records of the Claims Administrator.

EMERGENCY – The sudden and unexpected onset of a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the Covered Person's health, or in the case of a pregnant Covered Person, the health of the unborn child, in jeopardy;

B. Serious impairment to bodily functions; or

C. Serious dysfunction of any bodily organ or part.

EMERGENCY CARE – Covered Services and supplies provided by a Hospital or Facility Provider and/or Professional Provider to a Covered Person in or for an Emergency on an Outpatient basis in a Hospital Emergency Room or Outpatient Emergency Facility.

ENTERAL NUTRITION – the provision of nutritional requirements through a tube into the stomach or small intestine.

EXPERIMENTAL/INVESTIGATIONAL SERVICES – a drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

A. Is the subject of ongoing Phase I or Phase II Clinical Trials;

B. Is the research, experimental, study or investigational arm of on-going Phase III Clinical Trials or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;

C. Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;

D. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the particular diagnosis or treatment of the Covered Person's particular condition; or

E. Is generally recognized by either Reliable Evidence or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug will not be considered Experimental/Investigational if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the following established referenced compendia:

- The American Hospital Formulary Service Drug Information, or
- The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental/Investigational.

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

A. Reliable Evidence exists that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.

B. Reliable Evidence exists that over time the biological product, device, medical treatment or procedure leads to improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.

C. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

D. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigatory settings.

E. Reliable Evidence shows that the prevailing opinion among experts regarding the biological product, device, medical treatment or procedure is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment for a particular diagnosis.

FACILITY PROVIDER – an institution or entity licensed, where required, to provide care. Such facilities include:

- Ambulatory Surgical Facility
- Birth Center
- Free Standing Dialysis Facility
- Free Standing Ambulatory Care Facility
- Home Health Care Agency
- Hospice
- Hospital
- Rehabilitation Hospital
- Short Procedure Unit
- Skilled Nursing Facility

FAMILY COVERAGE – for you and one or more of your Dependents.

FREE STANDING AMBULATORY CARE FACILITY – a Facility Provider, other than a Hospital, which provides treatment or services on an Outpatient or partial basis and is not, other than incidentally, used as an office or clinic for the private practice of a Physician.

This facility shall be licensed by the state in which it is located and be accredited by the appropriate regulatory body.

FREE STANDING DIALYSIS FACILITY – a Facility Provider, licensed or approved by the appropriate governmental agency and approved by the Claims Administrator, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.

FUND or (ENROLLED FUND) – a Fund of Members which has been accepted by the Claims Administrator, consisting of all those active Applicants whose charges are remitted by the Applicant's Agent together with all the Members, listed on the Application Cards or amendments thereof, who have been accepted by the Claims Administrator.

HEARING AID – a Prosthetic that amplifies sound through simple acoustic amplification or through transduction of sound waves into mechanical energy that is perceived as sound. A Hearing Aid is comprised of (a) a microphone to pick up sound, (b) an amplifier to increase the sound, (c) a receiver to transmit the sound to the ear, and (d) a battery for power. A hearing aid may also have a transducer that changes sound energy into a different form of energy. The separate parts of a hearing aid can be packaged together into a small self-contained unit, or may remain separate or even require surgical implantation into the ear or part of the ear. Generally, a Hearing Aid will be categorized into one of the following common styles: (a) behind-the-ear, (b) in-the-ear, (c) in-the-canal, (d) completely-in-the-canal, and (e) implantable (can be partial or complete). A Hearing Aid is not a cochlear implant.

HOME HEALTH CARE AGENCY - a Facility Provider, approved by the Claims Administrator, that is engaged in providing, either directly or through an arrangement, health care services on an intermittent basis in the patient's home in accordance with an approved home health care Plan of Treatment.

HOSPICE – a Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals. The Hospice must be (1) certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and (2) appropriately licensed in the state where it is located.

HOSPITAL – a short-term, acute care, general Hospital which has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by the Claims Administrator and which:

A. is a duly licensed institution;

B. is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;

C. has organized departments of medicine;

D. provides 24-hour nursing service by or under the supervision of Registered Nurses;

E. is not, other than incidentally, a: Skilled Nursing Facility; nursing home; Custodial Care home; health resort, spa or sanitarium; place for rest; place for aged; place for treatment of Mental Illness; place for treatment of Alcohol or Drug Abuse; place for provision of rehabilitation care; place for treatment of pulmonary tuberculosis; place for provision of Hospice care.

IDENTIFICATION CARD – the currently effective card issued to you by the Claims Administrator which must be presented when a Covered Service is requested.

IMMEDIATE FAMILY – the Member's spouse, parent, child, stepchild, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law.

INCURRED – a charge shall be considered incurred on the date you or your Covered Dependent receives the service or supply for which the charge is made.

INDEPENDENT CLINICAL LABORATORY – a laboratory that performs clinical pathology procedure and that is not affiliated or associated with a Hospital, Physician or Facility Provider.

INPATIENT ADMISSION or (INPATIENT) – your actual entry into a Hospital, extended care facility or Facility Provider to receive Inpatient services as a registered bed patient in such Hospital, extended care facility or Facility Provider and for whom a room and board charge is made; the Inpatient Admission shall continue until such time as you are actually discharged from the facility.

LICENSED PRACTICAL NURSE (LPN) – a nurse who has graduated from a formal practical or nursing education program and is licensed by the appropriate state authority.

LIMITING AGE FOR DEPENDENTS – the age at which a Dependent child shall be removed from the Member's coverage. The Limiting Age for covered, unmarried children is shown in the Eligibility Under the Plan section.

MAINTENANCE – Continuation of care and management of the patient when the maximum therapeutic value of a Medically Appropriate/Medically Necessary treatment plan has been achieved, no additional functional improvement is apparent or expected to occur, the provision of Covered Services for a condition ceases to be of therapeutic value and is no longer Medically Appropriate/Medically Necessary. This includes Maintenance services that seek to prevent disease, promote health and prolong and enhance the quality of life.

MANAGED CARE ORGANIZATION (MCO) – a generic term for any organization that manages and controls medical service. It includes HMOs, PPOs, managed indemnity insurance programs and managed BCBS programs.

MAXIMUM – a limit on the amount of Covered Services that you may receive. The Maximum may apply to all Covered Services or selected types. When the Maximum is expressed in dollars, this Maximum is measured by the Covered Expenses, less deductibles, coinsurance and Copayment amounts paid by Covered Persons for the Services to which the Maximum applies. The Maximum may not be measured by the actual amounts paid by the Claims Administrator to the Providers. A Maximum may also be expressed in number of days or number of services for a specified period of time.

A. Benefit Maximum - the greatest amount of a specific Covered Service that a Covered Person may receive.

B. Lifetime Maximum - the greatest amount of Covered Services that a Covered Person may receive in his lifetime.

MEDICAL CARE – services rendered by a Professional Provider within the scope of his license for the treatment of an illness or injury.

MEDICAL FOODS – liquid nutritional products which are specifically formulated to treat one of the following genetic diseases: phenylketonuria, branched-chain ketonuria, galactosemia, homocystinuria.

MEDICALLY APPROPRIATE/MEDICALLY NECESSARY (or MEDICAL APPROPRIATENESS/MEDICAL NECESSITY) – an intervention will be covered if it is (a) a Covered Service, (b) not specifically excluded, and (c) Medically Appropriate/Medically Necessary. An intervention is Medically Appropriate/Medically Necessary if, as ordered by the treating Professional Provider and determined by the Claims Administrator's medical director or physician designee, it meets all of the following criteria:

A. ***It is a "Health Intervention"***. A Health Intervention is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat or palliate) a "medical condition" or to maintain or restore functional ability. A medical condition is one of the following: disease; illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human

variation. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

B. ***It is the most appropriate supply or level of service, considering potential benefits and harms to the Covered Person***.

C. ***It is known to be "effective" in improving "health outcomes"***

Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a "new" or "existing" intervention.

i. New interventions: Effectiveness is determined by Scientific Evidence. An intervention is considered new if it is not yet in widespread use for (a) the medical condition, and (b) the patient indications being considered.

"Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by (a) the natural history of the medical condition, or (b) potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

ii. Existing interventions: Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion.

For existing interventions, Scientific Evidence should be considered first and, to the greatest extent possible, be the basis for determinations of Medical Appropriateness/Medical Necessity.

If no Scientific Evidence is available, professional standards of care should be considered.

If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion.

Giving priority to Scientific Evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive Scientific Evidence.

Existing interventions can meet the contractual definition of Medical Appropriateness/Medical Necessity in the absence of Scientific Evidence if: (a) there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or, (b) in the absence of such standards, convincing expert opinion.

D. ***It is cost-effective for this condition compared to alternative interventions, including no intervention***.

"Cost effective" does not necessarily mean lowest price. An intervention is considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

An intervention may be medically indicated yet not be a Covered Service or meet this definition of Medical Appropriateness/Medical Necessity. An intervention is covered if: (a) it is a Covered Service; (b) it is not excluded from your coverage; and (c) it is Medically Appropriate/Medically Necessary.

MEDICARE – the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

MEDICARE ALLOWABLE PAYMENT – means the payment amount, as determined by the Medicare program, for a Covered Service or supply.

MEMBER – an individual of the Fund who meets the eligibility requirements for enrollment, who is so specified for enrollment, and in whose name the Identification Card is issued.

MEMBER FACILITY PROVIDER – a Facility Provider that is not part of the Preferred Provider Organization Network but is approved by and has a contractual relationship with the Claims Administrator for the provision of services to Covered Persons.

NON-MEMBER FACILITY PROVIDER – a Facility Provider that does not have a contractual relationship with the Claims Administrator or your local Blue Cross or Blue Shield Plan for the provision of services to Covered Persons.

NON-PARTICIPATING PROFESSIONAL PROVIDER – a Professional Provider who has not agreed to accept a rate of reimbursement determined by a contract with the Claims Administrator or your local Blue Cross or Blue Shield Plan for the provision of Covered Services to Covered Persons.

NON-PREFERRED ANCILLARY PROVIDER – an Ancillary Provider that is not a member of a BlueCard PPO Network or any other Blue Cross or Blue Shield Preferred Provider Network.

NON-PREFERRED FACILITY PROVIDER – a Facility Provider that is not a member of a BlueCard PPO Network or any other Blue Cross or Blue Shield Preferred Provider Network.

NON-PREFERRED PROFESSIONAL PROVIDER – a Professional Provider who is not a member of a BlueCard PPO Network or any other Blue Cross or Blue Shield Preferred Provider Network.

NON-PREFERRED PROVIDER – a Facility Provider, Professional Provider or Ancillary Provider that is not a member of a BlueCard PPO Network or any other Blue Cross or Blue Shield Preferred Provider Network.

NUTRITIONAL FORMULA – liquid nutritional products which are formulated to supplement or replace normal food products.

OUT-OF-POCKET LIMIT – a specified dollar amount of Coinsurance expense Incurred by a Covered Person for Covered Services in a Benefit Period. Such expense does not include any Deductible, penalties, Inpatient or Outpatient mental health services, or Copayment amounts. When the Out-of-Pocket Limit is reached, the level of benefits is increased as specified in the Schedule of Benefits.

OUTPATIENT CARE – medical, nursing, counseling or therapeutic treatment provided to a Covered Person who does not require an overnight stay in a Hospital or other inpatient facility.

OUTPATIENT DIABETIC EDUCATION PROGRAM – an outpatient diabetic education program provided by a Preferred Facility Provider which has been recognized by the Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

PARTICIPATING PROFESSIONAL PROVIDER – a Professional Provider who has agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.

PENALTY – a type of cost-sharing in which the Covered Person is assessed a percentage reduction in benefits payable for failure to obtain Precertification of certain Covered Services. Penalties, if any, are identified in the Schedule of Benefits and explained in detail in the Managed Care section.

PERVASIVE DEVELOPMENTAL DISORDERS (PDD) – disorders characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests and activities. Examples are Asperger's syndrome and childhood disintegrative disorder.

PHYSICIAN – a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed, and legally entitled to practice medicine in all its branches, perform Surgery and dispense drugs.

PLAN ADMINISTRATOR – the person or entity that has discretionary authority or responsibility to control and manage the operation and administration of this Plan, as provided in the documents establishing this Plan, in accordance with Employee Retirement Income Security Act (ERISA). **THE CLAIMS ADMINISTRATOR IS NOT THE PLAN ADMINISTRATOR UNDER THE COVERAGE OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE FUND**.

PLAN OF TREATMENT – a plan of care which is prescribed in writing by a Professional Provider for the treatment of an injury or illness. The Plan of Treatment should be limited in scope and extent to that care which is Medically Appropriate/Medically Necessary for the Covered Person's diagnosis and condition.

PRECERTIFICATION (or PRECERTIFY) – prior assessment by the Claims Administrator or a designated agent that proposed services, such as hospitalization, are Medically Appropriate/Medically Necessary for a particular patient and covered by the patient's Preferred Provider Organization plan. Payment for services depends on whether the patient and the category of service are covered under the individual's plan of coverage.

PREFERRED ANCILLARY PROVIDER – an Ancillary Provider that is a member of a BlueCard PPO Network and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services and/or supplies to Covered Persons.

PREFERRED FACILITY PROVIDER – a Facility Provider that is a member of a BlueCard PPO Network and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Covered Persons.

PREFERRED PROFESSIONAL PROVIDER – a Professional Provider who is a member of a BlueCard PPO Network and has agreed to a rate of reimbursement determined by contract for "in-network" Covered Services rendered to a Covered Person.

PREFERRED PROVIDER – a Facility Provider, Professional Provider or Ancillary Provider that is a member of a BlueCard PPO Network, authorized to perform specific "in-network" Covered Services at the Preferred level of benefits.

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

PRENOTIFICATION (or PRENOTIFY) – the requirement that a Covered Person provide prior notice to the Claims Administrator that proposed services, such as maternity care, are scheduled to be performed. Payment for services depends on whether the Covered Person and the category of service are covered under this Plan.

PRIMARY CARE SERVICES – basic, routine medical care traditionally provided to individuals with common illnesses and injuries and chronic illnesses.

PRIMARY CARE PROVIDER – a Professional Provider as listed in the Preferred Provider Organization Network directory under "Primary Care Physicians" (General Practice, Family Practice or Internal Medicine), "Obstetricians/Gynecologists" or "Pediatricians".

PRIVATE DUTY NURSING – Medically Appropriate/Medically Necessary Outpatient continuous skilled nursing services provided to a Covered Person by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

PROFESSIONAL PROVIDER – a person or practitioner licensed where required and performing services within the scope of such licensure. The Professional Providers are:

A. Audiologist
B. Certified Registered Nurse
C. Chiropractor
D. Dentist
E. Independent Clinical Laboratory
F. Nurse Midwife
G. Optometrist
H. Physical Therapist
I. Physician
J. Podiatrist
K. Speech-language Pathologist
L. Teacher of the hearing impaired

PROSTHETICS – devices (except dental prosthetics), which replace all or part of: (1) an absent body organ including contiguous tissue; or (2) the function of a permanently inoperative or malfunctioning body organ.

PROVIDER – a Facility Provider, Professional Provider or Ancillary Provider, licensed where required.

QUALIFYING CLINICAL TRIAL – the systematic, intensive investigation or evaluation of a drug, biological product, device, medical treatment, therapy or procedure that meets all of the following criteria:

A. Investigates a service that falls within a benefit category of this Contract;

B. Is not specifically excluded from coverage;

C. Has a therapeutic intent upon enrolled patients with diagnosed disease;

D. Is intended to clarify or establish health outcomes of interventions already in common clinical use as defined by the available Reliable Evidence;

E. Does not duplicate existing studies;

F. Is designed to collect and disseminate Reliable Evidence and answer specific research questions being asked in the trial;

G. Is designed and conducted according to appropriate standards of scientific integrity;

H. Complies with Federal regulations relating to the protection of human subjects;

I. Has a principal purpose to discern whether the service improves health outcomes on enrolled patients with diagnosed disease;

J. Is: (1) funded by, or supported by centers or cooperative groups that are funded by: the National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), or a research arm of the Department of Defense (DOD) or Department of Veterans Affairs (VA); or (2) conducted under an investigational new drug application (IND) reviewed by the FDA, or an Investigational New Drug Exemption as defined by the FDA;

K. Is conducted by a Preferred Professional Provider, and conducted in a Preferred Facility Provider. If there is no comparable Clinical Trial (as defined above) being conducted by a Preferred Provider, the Claims Administrator will consider a Clinical Trial being conducted by a Non-Preferred Provider as covered. In the absence of meeting the criteria listed above, the Clinical Trial must be approved by the Claims Administrator as a Qualifying Clinical Trial.

REASONABLE AND CUSTOMARY – means the amount that is the usual or customary charge for the service or supply as determined by the Claims Administrator. The chosen standard is an amount which is most often charged by other providers for similar services or supplies within the same geographic area where the service or supply is provided and who have training, experience and professional standing comparable to those of the actual provider of the service or supply. If no comparison exists, the Claims Administrator determines what is reasonable by the severity and/or complexity of the patient's condition for which the service or supply is provided.

REGISTERED NURSE (R.N.) – a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by the appropriate state authority.

REHABILITATION HOSPITAL – a Facility Provider, approved by the Claims Administrator and licensed by the appropriate regulatory agency, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

RELIABLE EVIDENCE – 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, biological product, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.

RESTORATIVE SERVICES – courses of treatments prescribed or provided by Professional Providers to restore loss of function of a body part. Restorative services generally involve neuromuscular training as a course of treatments over weeks or months. Examples of restorative services include, but are not limited to:

A. Manipulative treatment of functional loss from back disorder
B. Therapy treatment of functional loss following foot surgery
C. Orthoptic/Pleoptic therapy

ROUTINE COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS – Routine costs include: (a) Covered Services under this Contract that would typically be provided absent a Qualifying Clinical Trial; (b) services and supplies required solely for the provision of the Experimental/Investigational drug, biological product, device, medical treatment or procedure; (c) the clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications; and (d) the services and supplies required for the diagnosis or treatment of complications.

Routine costs do not include the Experimental/Investigational drug, biological product, device, medical treatment or procedure itself, the services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and services and supplies customarily provided by the research sponsors free of charge for any enrollee in the Qualifying Clinical Trial.

SEVERE SYSTEMIC PROTEIN ALLERGY – means allergic symptoms to ingested proteins of sufficient magnitude to cause weight loss or failure to gain weight, skin rash, respiratory symptoms, and gastrointestinal symptoms of significant magnitude to cause gastrointestinal bleeding and vomiting.

SHORT PROCEDURE UNIT – a unit which is approved by the Claims Administrator and which is designed to handle either lengthy diagnostic or minor surgical procedures on an Outpatient basis which would otherwise have resulted in an Inpatient stay in the absence of a Short Procedure Unit.

SKILLED NURSING FACILITY – an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of Mental Illness, tuberculosis, or Alcohol or Drug Abuse, which:

A. is accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or

B. is certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or

C. is otherwise acceptable to the Claims Administrator.

SPECIALIST SERVICES – all Professional Provider services providing medical or mental health/psychiatric care in any generally accepted medical or surgical specialty or subspecialty.

SURGERY – the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures. Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care. Treatment of burns, fractures and dislocations are also considered surgery.

THERAPY SERVICE – the following services or supplies prescribed by a Physician and used for the treatment of an illness or injury to promote the recovery of the Covered Person:

A. **CARDIAC REHABILITATION THERAPY** - Medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.

B. **CHEMOTHERAPY** - The treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics, and other related biotech products.

C. **DIALYSIS** - The treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.

D. **INFUSION THERAPY** - Treatment including, but not limited to infusion or inhalation, parenteral and Enteral Nutrition, antibiotic therapy, pain management and hydration therapy.

E. **OCCUPATIONAL THERAPY** - Medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational therapy also includes medically prescribed treatment concerned with improving the Covered Person's ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by illness or injury, congenital anomaly or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.

F. **PHYSICAL THERAPY** - Medically prescribed treatment of physical disabilities or impairments resulting from disease, injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.

G. **PULMONARY REHABILITATION THERAPY** - Multidisciplinary treatment which combines physical therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

H. **RADIATION THERAPY** - The treatment of disease by X-Ray, gamma ray, accelerated particles, mesons, neutrons, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery.

I. **RESPIRATORY THERAPY** - Medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.

J. **SPEECH THERAPY** - Medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.

TOTAL DISABILITY – means that you, due to illness or injury, cannot perform any duty of your occupation or any occupation for which you are, or may be, suited by education, training and experience, and you are not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Totally Disabled person must be under the regular care of a Physician.

URGENT CARE – Medically Appropriate/Medically Necessary Covered Services provided in order to treat an unexpected illness or Accidental Injury that is not life-or limb-threatening. Such Covered Services must be required in order to prevent a serious deterioration in the Covered Person’s health if treatment were delayed.

YOUR PREFERRED PROVIDER ORGANIZATION PLAN

Your Preferred Provider Network Plan (the Plan) is a program, which allows you to maximize your health care benefits by utilizing the Preferred Providers in your local PPO Network. These Providers are called "Preferred Providers" in this Booklet. You may think of them as "In-Network Providers". Preferred Providers are doctors, hospitals and other health care professionals and institutions that are part of your local BlueCard PPO Network, authorized to perform specific “in-network” Covered Services at the Preferred level of benefits.

When you receive health care through a Provider that is a member of your local BlueCard PPO Network, you are assured of little, if any, out-of-pocket expenses, and there are no claim forms to fill out. Benefits are also provided if you choose to receive health care through a Provider that is not a Preferred Provider. However, the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses. You may have to reach a deductible before receiving benefits, and you may be required to file a claim form.

To locate a BlueCard PPO network provider go to www.bluecares.com or call 1-800-810-BLUE (2583). The Claims Administrator covers only care that is Medically Appropriate/Medically Necessary. Medically Appropriate/Medically Necessary care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in Short Procedure Units and care in a Hospital Outpatient Department.

Some of the services you receive through this Plan must be pre-certified before you receive them, to determine whether they are Medically Appropriate/Medically Necessary. Failure to precertify Covered Services, when required, may result in a reduction of benefits. Precertification of services is a vital program feature that reviews Medical Appropriateness/Medical Necessity of certain procedures/admissions. In certain cases, Precertification helps determine whether a different treatment may be available that is equally effective yet less traumatic. Precertification also helps determine the most appropriate setting for certain services. The latest innovations in health care enable doctors to provide services, once provided exclusively in an inpatient setting, in many different settings – such as an outpatient department of a hospital or a doctor’s office.

When you need to seek medical treatment that requires Precertification, you must ask your Provider to initiate the Precertification process. The precertification number is listed on the back of your Identification Card. The provider should give your name, facility’s name, diagnosis, and procedure or reason for admission. Failure to precertify required services will result in a reduction of benefits payable to you.

If the request for Precertification is denied, you will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate. If you decide to continue treatment or care that has not been approved, you will be asked to do the following:

1. Acknowledge this in writing.
2. Request to have services provided.
3. State your willingness to assume financial liability.

HOW TO FILE A CLAIM

Most BlueCard PPO providers will file claims for you. Simply present your Identification Card at the time the services are provided. You may call 1-800-810-BLUE (2583) for assistance in finding BlueCard PPO Preferred Providers. When you receive care from a Non-Preferred Provider, you will need to file a claim to receive benefits. If you do not have a claim form, call the number listed on the back of your Identification Card, and a claim form will be sent to you. Fill out the claim form and return it with your itemized bills to Horizon Blue Cross/Blue Shield of New Jersey at the address listed on the claim form no later than 20 days after completion of the Covered Services.

The itemized bill should contain the following information:

(1) patient's name and address;
(2) date of service;
(3) type of service and diagnosis;
(4) itemized charges;
(5) provider's complete name and address.

An expense will be considered Incurred on the date the service or supply was rendered.

If it was not possible to file the claim within the 20-day period, your benefits will not be reduced, but in no event will the Claims Administrator be required to accept the claim more than two years after the end of the Benefit Period in which the Covered Services are rendered.

PAYMENT OF PROVIDERS

Covered Person or the Provider may submit bills directly to the Claims Administrator, and, to the extent that benefits and indemnity are payable within the terms and conditions of this coverage, reimbursement will be furnished as detailed below. The Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits for Covered Services are based on the rate of reimbursement as defined under "Covered Expense" in the Defined Terms section of this Booklet.

Facility Providers

Preferred Facility Providers

Preferred Facility Providers are members of the Preferred Provider Organization Network or a BlueCard PPO Network and have a contractual arrangement for the provision of services to Covered Persons. Benefits will be provided as specified in the Schedule of Benefits for services which have been performed by a Preferred Facility Provider. The Claims Administrator will compensate Preferred Facility Providers in accordance with the contracts entered into between such Providers and the Claims Administrator. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Facility Provider.

Non-Preferred Facility Providers

Non-Preferred Facility Providers include facilities that are not part of the Preferred Provider Organization's Network, a BlueCard PPO Network, or any other Blue Cross or Blue Shield Preferred Provider Network. The Claims Administrator may have a contractual arrangement with a facility even if it is not part of its Preferred Organization Network. Non-Preferred Member Facility Providers that have contracts with the Claims Administrator will be compensated in accordance with the contracts entered into between such Providers and the Claims Administrator.

A Non-Preferred Non-Member Facility Provider is a Facility Provider which does not belong to your local Preferred Provider Organization Network, nor does it have a contract with the Claims Administrator or any other Blue Cross or Blue Shield Preferred Provider Network. The Claims Administrator will provide benefits at a Non-Preferred Non-Member Provider at the Non-Preferred coinsurance level specified in the Schedule of Benefits.

If the Claims Administrator determines that Covered Services were for Emergency Care as defined herein, the Covered Person normally will not be subject to the cost sharing penalties that would ordinarily be applicable to Non-Preferred services. Emergency admissions must be certified within two (2) business days of admission, or as soon as reasonably possible, as determined by the Claims Administrator. The Claims Administrator will provide benefits for the Covered Expenses incurred for certain medical services when rendered incident to hospitalization, as described herein. If charges for such services are included in a bill from a Preferred Facility Provider or a Member Facility Provider, payment shall be made to such Facility Provider subject to any existing agreement between the Facility Provider and the Claims Administrator.

Once Covered Services are rendered by a Facility Provider, the Plan will not honor a Covered Person's request not to pay for claims submitted by the Facility Provider. The Covered Person will have no liability to any person because of its rejection of the request.

Professional Providers

The Claims Administrator is authorized by the Covered Person to make payment directly to the Preferred and Participating Professional Providers furnishing Covered Services for which benefits are provided under this coverage. Most Preferred and Participating Professional Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. Most Preferred and Participating Professional Providers will make no additional charge to Covered Persons for Covered Services except in the case of certain Copayments, Coinsurance or other cost sharing features as specified under this program. However, not all Preferred and Participating Professional Providers have agreed to hold members harmless from balance bills. The Covered Person is responsible within 60 days of the date in which the Claims Administrator finalizes such services to pay, or make arrangements to pay, such amounts to the Preferred and Participating Professional Provider.

Benefit amounts, as specified in the Schedule of Benefits of this coverage, refer to Covered Services rendered by a Professional Provider which are regularly included in such Provider's charges and are billed by and payable to such Provider. Any dispute between the Preferred Professional Provider and a Covered Person with respect to balance billing shall be submitted to the Claims Administrator for determination. The decision of the Claims Administrator shall be final.

Non-Preferred Professional Provider Reimbursement

When Covered Services are performed by a Non-Preferred Professional Provider, the Claims Administrator will make payment to the Covered Person, subject to any applicable Coinsurance or other cost sharing penalty on services by Non-Preferred Professional Providers. When a Covered Person seeks care from a Non-Preferred Participating Professional Provider, payment will be made in accordance with the rate of reimbursement determined by the contract between the Professional Provider and the Claims Administrator. When a Covered Person seeks care from a Non-Preferred, Non-Participating Professional Provider, payment will be the amount as determined by the Claims Administrator's lowest network fee schedule that the Claims Administrator would have paid to a Preferred Professional Provider for the same service or the charge, whichever is less. Accordingly, when a Covered Person seeks care from Non-Preferred, Non-Participating Professional Providers, any difference between the Non-Preferred Professional Provider's charge and the Claims Administrator's payment shall be the personal responsibility of the Covered Person.

If the Claims Administrator determines that services were performed during an emergency, the Covered Person will not be subject to the cost-sharing features ordinarily applicable to Covered Services rendered by Non-Preferred Professional Providers.

Once Covered Services are rendered by a Professional Provider, the Claims Administrator will not honor a Covered Person's request not to pay for claims submitted by the Professional Provider. The Claims Administrator will have no liability to any person because of its rejection of the request.

Ancillary Providers

Preferred Ancillary Providers

Preferred Ancillary Providers include members of your local Preferred Provider Organization's Network or any other BlueCard PPO Network. Benefits will be provided as specified in the Schedule of Benefits for the provision of services or supplies provided to Covered Persons by Preferred Ancillary Providers. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Ancillary Provider.

Non-Preferred Ancillary Providers

Non-Preferred Ancillary Providers are not members of the Preferred Provider Organization's Network or any other BlueCard PPO Network. Benefits will be provided to the Covered Person at the Non-Preferred coinsurance level specified in the Schedule of Benefits. The Covered Person will be penalized by the application of higher cost sharing as detailed in the Schedule of Benefits.

Assignment of Benefits to Providers

The right of a Covered Person to receive benefit payments under this coverage is personal to the Covered Person and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefits of this coverage be transferred, either before or after Covered Services are rendered. However, a Covered Person can assign benefit payments to the custodial parent of a Dependent covered under the Group Contract, as required by law.

BLUECARD PPO PROGRAM

When you obtain health care services through BlueCard outside the geographic area Horizon Blue Cross/Blue Shield of New Jersey ("HORIZON") serves, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Plan") passes on to us.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating a Covered Person's liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, HORIZON would then calculate your liability for any covered health care services in accordance with the applicable Host Blue state statute in effect at the time you received your care.

DEDUCTIBLE

You must pay a portion of your covered medical expenses before the Carrier begins to pay for benefits. A Deductible must be met each Benefit Period before payment will be made for Covered Services. See the Schedule of Benefits section for the Deductible amount and the services to which the Deductible is applicable.

Expenses incurred for Preferred and Non-Preferred Services in the last three (3) months of a Benefit Period which were applied to that year's Preferred and Non-Preferred Deductible will be applied to the Deductible for the next Benefit Period.

No more than two times the individual Deductible under one Family Coverage must be satisfied in each Benefit Period. However, no family member may contribute more than the individual Deductible amount.

COINSURANCE

Coinsurance is a percentage of the Covered Expenses that must be paid by you or your covered Dependents; it is applied after the Deductible, if any, is met. Coinsurance is applied to most Covered Services, when they are received from some Preferred Providers and most Non-Preferred Providers. Refer to the Schedule of Benefits for specific Coinsurance amounts.

Limits on Coinsurance Liability

There is a Maximum placed on the amount of Coinsurance which you are required to pay each Benefit Period. This Maximum is called your "Out-of-Pocket Coinsurance Limit ". See the Schedule of Benefits section for the Outof-Pocket Coinsurance Limit amounts.

For each Covered Person, when the Preferred and Non-Preferred Out-of-Pocket Limit is reached, the Claims Administrator will pay 100% of the Covered Expenses for Preferred and Non-Preferred services incurred during the balance of the Benefit Period.

Out-of-Pocket expenses incurred for Non-Preferred Covered Services do not count toward the Preferred Out-of-Pocket Limit.

LIFETIME MAXIMUM

There is a Lifetime maximum for all Preferred and Non-Preferred services. Benefits will cease after benefits for the Preferred and Non-Preferred care exceed the individual Lifetime Maximum. The calculation of benefits paid shall begin from the Covered Person's first participation in the Fund and shall include all medical benefits paid on behalf of the Covered Person regardless of which medical benefit program (Traditional, PPO medical or HMO medical) under which the Covered Person was or is enrolled.

See the Schedule of Benefits for the Lifetime Maximum amount.

Amounts applied to the Covered Person's Lifetime Maximum are not restorable.

ELIGIBILITY UNDER THE PLAN

Who Is Eligible and When?

Effective Date: The date the Fund agrees that all Eligible Persons may apply and become covered for the benefits as set forth in the Fund Contract and described in this booklet. If a person becomes an eligible person after the Fund's Effective Date, that date becomes the Effective Date.

ELIGIBLE PERSON

You are eligible to be covered under this PPO Plan if you are determined by the Fund as eligible to apply for coverage and sign the Application.

Eligibility shall not be affected by your physical condition and determination of eligibility for the coverage by the Fund shall be final and binding.

SPECIAL NOTE FOR PART-TIME EMPLOYEES:

If you are or become a part-time employee, as determined by the Health & Welfare Fund, the benefits described in this booklet are limited to you, the employee. Contact the Fund if you are unsure as to your status as a full-time or part-time employee.

ELIGIBLE DEPENDENT

If you are a Full-Time Employee, your family is eligible for coverage (Dependent coverage) when you are eligible for Member coverage. No coverage is provided for the spouse or Dependent children of a Part-time Employee.

An Eligible Dependent is defined as your spouse under a legally valid existing marriage, provided you are not separated as defined by the Fund’s benefit plan, your unmarried child(ren), including any stepchild, legally adopted child, a child placed for adoption or any child whose coverage is your responsibility under the terms of a qualified release or court order. The limiting age for covered, unmarried children is to the date on which they reach age 19; or if a student is enrolled full-time in an Accredited Educational Institution, the limiting age is not beyond the date on which they reach age 23 or the date of graduation, whichever first occurs.

Eligibility will be continued past the limiting age for unmarried children, regardless of age, who are incapable of self-support because of mental or physical incapacitation and who are dependent on you for over half of their support. The Plan may require proof of your eligibility under the prior Claims Administrator's plan and also from time to time under this Plan.

The newborn child(ren) of you or your spouse shall be entitled to the benefits provided by the Plan from the date of birth for a period of 31 days. Coverage of newborn children within such 31 days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. To be eligible for Dependent coverage beyond the 31 day period, you must enroll the newborn child within such 31 days. To continue coverage beyond 31 days for a newborn child, who does not otherwise qualify for coverage as a Dependent, you must apply within 31 days after the birth of the newborn and the appropriate rate must be paid when billed.

A newly acquired Dependent shall be eligible for coverage under the Plan on the date the Dependent is acquired provided that you apply to the Claims Administrator for addition of the Dependent within 31 days after the Dependent is acquired and you make timely payment of the appropriate rate. If Application is made later than 31 days after the Dependent is acquired, coverage shall become effective on the first billing date following 30 days after your Application is accepted by the Claims Administrator.

A Dependent child of a custodial parent covered under the Fund coverage may be enrolled under the terms of a qualified medical release or court order, as required by law.

YOUR PREFERRED PROVIDER ORGANIZATION BENEFITS

All Inpatient Hospital Admissions, other than a maternity admission or an admission for a Medical Emergency, and certain other services as described in this section below must receive precertification in accordance with the requirements contained in the Managed Care section of this booklet. Admissions for a Medical Emergency must be reviewed within two (2) business days of the admission, or as soon as reasonably possible, as determined by the Claims Administrator.

The services described below may be provided by either a Preferred or Non-Preferred Provider. However, the Covered Person will maximize the benefits available when services are provided by a Provider that belongs to your Preferred Provider Organization's Network or another Blue Cross and Blue Shield Plan's BlueCard PPO Network (a Preferred or "In-Network" Provider) that has a contract with the Claims Administrator or another Blue Cross or Blue Shield Plan to provide services and supplies to the Covered Person. To locate a BlueCard PPO Network Provider go to www.bcbs.com or call 1-800-810-BLUE (2583).

PRIMARY AND PREVENTIVE CARE SERVICES

A Covered Person is entitled to benefits for Primary Care and "Preventive Care" Covered Services when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the ***Schedule of Benefits***.

"Preventive Care" services generally describe health care services performed to catch the early warning signs of health problems. These services are performed when the Covered Person has no symptoms of disease. Services performed to treat an illness or injury are not covered as Preventive Care under this benefit.

The Claims Administrator periodically reviews the schedule of Covered Services based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force and The American Cancer Society. Accordingly, the frequency and eligibility of Covered Services are subject to change. The Claims Administrator reserves the right to modify the schedule at any time after written notice of the change has been given to the Covered Person.

A. Office Visits

Medical care visits for the examination, diagnosis and treatment of an illness or injury by a Primary Care Provider. For the purpose of this benefit, "Office Visits" include medical care visits to a Provider's office, medical care visits by a Provider to a Covered Person's residence, or medical care consultations by a Provider on an Outpatient basis.

B. Pediatric Preventive Care

Pediatric Preventive Care includes the following:

1. **Physical Examination, Routine History, Routine Diagnostic Tests**. Well baby care, which generally includes a medical history, height and weight measurement, physical examination and counseling, is limited to Covered Persons under eighteen (18) years of age in accordance with the schedule shown below. When a range is given (i.e., 2-3 months), the dash indicates that coverage is available for one service from two (2) months through three (3) months of age.

   Twenty-four (24) examinations up to age seventeen (17) – according to each of the following age groupings:

   - Eight (8) exams between the ages of 0-24 months within the following age ranges:

0-1 month	9-11 months
2-3 months	12-14 months
4-5 months	15-17 months
6-8 months	18-24 months

- One (1) exam every calendar year between two (2) and seventeen (17) years of age

2. **Blood Lead Screening**. This blood test detects elevated lead levels in the blood. Children are covered for:

   - One (1) test between 9-12 months of age
   - One (1) test at twenty-four (24) months of age

3. **Hemoglobin/Hematocrit**. This blood test measures the size, shape, number and content of red blood cells. Children are covered for:

   - One (1) test between 0-12 months of age
   - One (1) test between one (1) and four (4) years of age
   - One (1) test between five (5) and twelve (12) years of age
   - One (1) test between thirteen (13) and seventeen (17) years of age

4. **Rubella Titer Test**. The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, the rubella immunization should be given. The rubella titer blood test is recommended when it is unsure whether the child has ever been immunized. Children are covered for one (1) test and immunization between eleven (11) and seventeen (17) years of age.

5. **Urinalysis**. This test detects numerous abnormalities. Children are covered for:

   - One (1) test every 365 days between 0-24 months of age
   - One (1) test every calendar year between two (2) and seventeen (17) years of age

C. Pediatric Immunizations

Coverage will be provided for those pediatric immunizations, including the immunizing agents, which, as determined by the Department of Health, conform with the Standards of the (Advisory Committee on Immunization Practices of the Center for Disease Control) U.S. Department of Health and Human Services. Benefits are limited to Covered Persons under twenty-one (21) years of age.

Effective December 1, 2006, coverage will be provided, with a patient copayment of $35.00 per injection for the series of injections for immunization, including the immunizing agents, for the Human Papillomavirus (HPV) Vaccine for female participants between the ages of eleven (11) and twenty-six (26).

D. Adult Preventive Care

1. **Physical Examination, Routine History**. Well person care, which generally includes a medical history, height and weight measurement, physical examination and counseling, plus necessary Diagnostic Services, is limited to Covered Persons eighteen (18) years of age or older in accordance with the following schedule:

   - One (1) examination every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age

   - One (1) examination every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age

   - One (1) examination every calendar year, beginning at forty (40) years of age

2. **Adult Tetanus Toxoid (TD)**. This immunization provides immunity against tetanus and diphtheria.

   - One (1) test every ten (10) calendar years, beginning at eighteen (18) years of age

3. **Blood Cholesterol Test**. This blood test measures the total serum cholesterol level. High blood cholesterol is one of the risk factors that leads to coronary artery disease.

- One (1) test every four (4) calendar years between eighteen (18) and thirty-nine (39) years of age
- One (1) examination every calendar year, beginning at forty (40) years of age

4. **Complete Blood Count (CBC)**. This blood test checks the red and white blood cell levels, hemoglobin and hematocrit.

   - One (1) test every calendar year at eighteen (18), nineteen (19), twenty (20), and twenty-one (21) years of age
   - One (1) examination every three (3) calendar years between twenty-two (22) and thirty-nine (39) years of age
   - One (1) test every calendar year, beginning at forty (40) years of age

5. **Fecal Occult Blood Test**. This test checks for the presence of blood in the feces which is an early indicator of colorectal cancer.
   - One (1) test every calendar year, beginning at fifty (50) years of age

6. **Flexible Sigmoidoscopy**. This test detects colorectal cancer by use of a flexible fiberoptic sigmoidoscope.

   - One (1) test every three (3) calendar years, beginning at fifty (50) years of age

7. **Influenza Vaccine**. This vaccine provides immunization against influenza type A and B viruses.

   - One (1) vaccine every calendar year, beginning at eighteen (18) years of age

8. **Pneumococcal Vaccine**. This vaccine provides immunization against pneumococcal disease. Pneumococcal disease may cause pneumonia and other infections such as meningitis and bronchitis.

   - One (1) vaccine every five (5) calendar years, beginning at sixty-four (64) years of age

9. **Prostate Specific Antigen (PSA)**. This blood test may be used to detect tumors of the prostate.

   - One (1) test every calendar year, beginning at fifty (50) years of age

10. **Routine Colonoscopy**. This test detects colorectal cancer by use of a flexible fiberoptic colonoscope.

    - One (1) test every ten (10) calendar years, beginning at fifty (50) years of age

11. **Rubella Titer Test**. The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, the rubella immunization should be given. The rubella titer blood test is recommended when it is unsure whether the adult has ever been immunized.

    - One (1) test and immunization between eighteen (18) and forty-nine (49) years of age

12. **Thyroid Function Test**. This test detects hyperthyroidism and hypothyroidism.

    - One (1) series of tests every calendar year, beginning at eighteen (18) years of age

13. **Urinalysis**. This test detects numerous abnormalities.

    - One (1) test every calendar year, beginning at eighteen (18) years of age

14. **Varicella Vaccine**. This vaccine is recommended for women of childbearing age who have not been previously exposed to the chicken pox virus.

    - One (1) immunization for women between eighteen (18) and forty-nine (49) years of age

15. **Osteoporosis Screening (Bone Mineral Density Testing or BMDT)**. Coverage is provided for Bone Mineral Density Testing using a U.S. Food and Drug Administration approved method. This test

determines the amount of mineral in a specific area of the bone. It is used to measure bone strength which is the aggregate of bone density and bone quality. Bone quality refers to architecture, turnover and mineralization of bone. The BMDT must be prescribed by a Professional Provider legally authorized to prescribe such items under law.

- One screening test every two calendar years beginning at age 65

16. **<u>Fasting Blood Glucose Test</u>**. This test is used for detection of diabetes.

    - One (1) test every three (3) years, beginning at age forty-five (45).

17. **<u>Abdominal Aortic Aneurysm Screening</u>**. One (1) test per lifetime is recommended for men with a smoking history.

    - One (1) ultrasound for men between sixty-five (65) and seventy-five (75) years of age.

E. **Routine Gynecological Examination, Pap Smear**

Female Covered Persons are covered for one (1) routine gynecological examination each calendar year, including a pelvic examination and clinical breast examination; and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists.

F. Mammograms

Coverage will be provided for screening and diagnostic mammograms. Benefits for mammography are payable only if performed by a qualified mammography service provider who is properly certified by the appropriate state or federal agency in accordance with the Mammography Quality Assurance Act of 1992.

G. High Risk Immunizations

- Benefits are payable for certain immunizations provided to Covered Persons determined to be at “high risk” as determined by the Claims Administrator.

H. Therapeutic Injections

- Therapeutic injections required in the treatment of an injury or illness.

I. Allergy Injections

- Benefits are provided for allergy extracts and allergy injections.

The Claims Administrator periodically reviews the schedule of covered services based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force and The American Cancer Society. Accordingly, the frequency and eligibility of services is subject to change.

Therefore, the Claims Administrator reserves the right to modify this schedule from time to time.

INPATIENT SERVICES

A Covered Person is entitled to benefits for Covered Services while an Inpatient in a Facility Provider, when deemed Medically Appropriate/Medically Necessary and billed for by a Facility Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the Schedule of Benefits.

All Inpatient Admissions, other than an Emergency admission, must be precertified by the Claims Administrator in accordance with the requirements contained in the Managed Care section of this booklet. Emergency admissions must be reviewed within 2 business days of the admission or as soon as reasonably possible. A concurrent

review is required for any continued length of stay beyond what has been Pre-Certified by the Claims Administrator.

A. HOSPITAL SERVICES

ROOM AND BOARD

Benefits will be paid for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:

a. an average semi-private room, as designated by the Hospital; or a private room, when designated by the Claims Administrator as semi-private for the purposes of this coverage in Hospitals having primarily private rooms;

b. a private room, when Medically Appropriate/Medically Necessary;

c. a Special Care Unit, such as Intensive or Coronary Care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;

d. a bed in a general ward; and

e. nursery facilities.

Benefits are provided for up to the number of days specified in the Schedule of Benefits.

In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one day.

Days available under this coverage shall be allowed only during uninterrupted stays in a Hospital. Benefits shall not be provided: (1) during the absence of a Covered Person who interrupts his stay and remains past midnight of the day on which the interruption occurred; or (2) after the discharge hour that the Covered Person's attending Physician has recommended that further Inpatient care is not required.

ANCILLARY SERVICES

Benefits are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items) including but not limited to the following:

a. meals, including special meals or dietary services as required by the patient's condition;

b. use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;

c. casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;

d. oxygen and oxygen therapy;

e. administration of blood and blood plasma, including the processing of blood from donors, but excluding the blood or blood plasma, except as may be provided within this coverage;

f. anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;

g. Physical Therapy, Cardiac Rehabilitation Therapy, Respiratory Therapy, hydrotherapy, Speech Therapy, and/or Occupational Therapy when administered by a person who is appropriately licensed and authorized to perform such services;

h. Radiation Therapy;

i. Chemotherapy;

j. all drugs and medications (including intravenous injections and solutions) for use while in the Hospital and which are released for general use and are commercially available to Hospitals;

k. use of Special Care Units, including but not limited to, Intensive or Coronary Care; and

l. Preadmission testing.

Subject to the Exclusions, conditions and limitations of this coverage, a Covered Person is entitled to benefits for Covered Services when: (1) deemed Medically Appropriate/Medically Necessary and (2) billed for by a Provider.

B. MEDICAL CARE

Medical Care provided by the Professional Provider in charge of the case to a Covered Person who is an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility for a condition not related to Surgery, pregnancy, Radiation Therapy, or Mental Illness, except as specifically provided. Such care includes Inpatient intensive Medical Care rendered to a Covered Person whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period of time.

1. Concurrent Care

Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations or Medical Care routinely performed in the pre-or post-operative or pre-or post-natal periods or Medical Care required by a Facility Provider's rules and regulations.

2. Consultations

Consultation services when rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider at the request of the attending Professional Provider. Consultations do not include staff consultations which are required by Facility Provider's rules and regulations. Benefits are limited to one (1) consultation per consultant during any inpatient confinement.

C. SKILLED NURSING FACILITY

Benefits are provided for a Skilled Nursing Facility, when Medically Appropriate/Medically Necessary as determined by the Claims Administrator, up to the Maximum days specified in the Schedule of Benefits. The Covered Person must require treatment by skilled nursing personnel which can be provided only on an Inpatient basis in a Skilled Nursing Facility. For maximum benefits, admission to a Skilled Nursing Facility must be pre-certified as an Inpatient admission in accordance with the Managed Care section of this booklet.

Medically Necessary Professional Provider visits in a Skilled Nursing Facility are provided as shown in the Schedule of Benefits.

No benefits are payable:

1. when confinement in a Skilled Nursing Facility is intended solely to assist the Covered Person with the activities of daily living or to provide an institutional environment for the convenience of a Covered Person;

2. for the treatment of alcohol and drug addiction, and Mental Illness; or

3. after the Covered Person has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine custodial care.

INPATIENT/OUTPATIENT BENEFITS

A Covered Person is entitled to benefits for Covered Services either while an Inpatient in a Facility Provider or on an Outpatient basis when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the Schedule of Benefits.

A. BLOOD

Benefits shall be payable for the administration of Blood and Blood processing from donors. Benefits shall be payable for autologous Blood drawing, storage or transfusion - i.e., an individual having his own Blood drawn and stored for personal use, such as self-donation in advance of planned Surgery.

Benefits shall be payable for whole Blood, Blood plasma and Blood derivatives, which are not classified as drugs in the official formularies and which have not been replaced by a donor.

B. HOSPICE SERVICES

When the Covered Person's attending Physician certifies that the Covered Person has a terminal illness with a medical prognosis of six (6) months or less and when the Covered Person elects to receive care primarily to relieve pain, the Covered Person shall be eligible for Hospice benefits. Hospice Care is primarily comfort care, including pain relief, physical care, counseling and other services that will help the Covered Person cope with a terminal illness rather than cure it. Hospice Care provides services to make the Covered Person as comfortable and pain-free as possible. When a Covered Person elects to receive Hospice Care, benefits for treatment provided to cure the terminal illness are no longer provided. However, the Covered Person may elect to revoke the election of Hospice Care at any time.

Respite Care: When Hospice Care is provided primarily in the home, such care on a short-term Inpatient basis in a Medicare certified Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the Covered Person's home. Up to seven (7) days of such care every six (6) months will be covered. Benefits for Covered Hospice Services shall be provided until the earlier of the Covered Person's death or discharge from Hospice Care.

Special Hospice Services Exclusions: No Hospice Care benefits will be provided for:

1. Services and supplies for which there is no charge;
2. Research studies directed to life lengthening methods of treatment;
3. Services or expenses incurred in regard to the Covered Person's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property);
4. Care provided by family members, relatives, and friends; and
5. Private Duty Nursing care.

C. MATERNITY/OB-GYN/FAMILY SERVICES

1. **Maternity/Obstetrical Care**

Services rendered in the care and management of a pregnancy for a Member or spouse are a Covered Expense under this Plan as specified in the *Schedule of Benefits*.

Prenotification of maternity care should occur within one (1) month of the first prenatal visit to the Physician or midwife. Benefits are payable for: (1) facility services provided by a Hospital or Birth Center; and (2) professional services performed by a Professional Provider or certified nurse midwife.

Benefits payable for a delivery shall include pre- and post-natal care. Maternity care Inpatient benefits will be provided for forty-eight (48) hours for vaginal deliveries and ninety-six (96) hours for cesarean deliveries, except where otherwise approved by the Claims Administrator as provided for in the *Managed Care* section.

In the event of early post-partum discharge from an Inpatient Admission, benefits are provided for Home Health Care as provided for in the Home Health Care subsection.

Under this program, coverage for pregnancy for Dependent daughters shall include only those services which are provided for conditions classified as Complications of Pregnancy.

2. **Therapeutic Abortions**

Facility services provided by a Hospital or Birth Center and services performed by a Professional Provider for the voluntary termination of a pregnancy by a Member or Member's spouse are a Covered Expense: (a) when necessary to avert the death of the mother, and (b) for termination of pregnancy related to either rape or incest.

3. **Newborn Care**

For Full-Time Employees, the newborn child of a Member or Dependent Spouse shall be entitled to benefits provided by this Plan from the date of birth up to a maximum of thirty-one (31) days. Such coverage within the thirty-one (31) days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery. Coverage for a newborn may be continued beyond thirty-one (31) days under conditions specified in the *Eligibility Under this Plan* section.

For Part-Time Employees, coverage for newborns is limited to routine nursery care from the date of birth to Member's discharge from the hospital, when billed as a part of the Member's claim.

D. BEHAVIORAL HEALTH SERVICES

Coverage for Behavioral Health services (including treatment of psychiatric conditions and alcohol and drug abuse), is not provided under your PPO benefit program, and the Claims Administrator plays no role in the administration of Behavior Health services for the Fund. Behavioral Health services are provided through the Fund's Behavioral Health program administrator, which is not affiliated with the Claims Administrator. The details of your benefits for Behavioral Health services appear in the "Behavioral Health" section of the Fund's Summary Plan Description.

E. ROUTINE COSTS ASSOCIATED WITH QUALIFYING CLINICAL TRIALS

Benefits are provided for Routine Costs Associated With Participation in a Qualifying Clinical Trial (see the Defined Terms section). To ensure coverage, the Claims Administrator must be notified in advance of the Covered Person's participation in a Qualifying Clinical Trial.

F. SURGICAL SERVICES

Surgery benefits will be provided for services rendered by a Professional Provider and/or Facility Provider for the treatment of disease or injury. Separate payment will not be made for Inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure. Also covered is (1) the orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus; and (2) coverage for the following when performed subsequent to mastectomy: surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Coverage is also provided for: (a) the initial and subsequent insertion or removal of prosthetic devices to replace the removed breast or portions thereof; and (b) the treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Failure to obtain preprocedure certification for these services will result in a 20% reduction of the benefits payable for surgical services.

Covered surgical procedures shall include routine neonatal circumcisions and any voluntary surgical procedure for sterilization.

1. **<u>Hospital Admission for Dental Procedures or Dental Surgery</u>**

   Benefits will be payable for a Hospital admission in connection with dental procedures or Surgery only when the Covered Person has an existing non-dental physical disorder or condition and hospitalization is Medically Appropriate/ Medically Necessary to ensure the patient's health. Coverage for such hospitalization does not imply coverage of the dental procedures or Surgery performed during such a confinement. Only oral surgical procedures specifically identified as covered under the "Oral Surgery" terms of this Plan will be covered during such a confinement.

2. **<u>Oral Surgery</u>**

   Benefits will be payable for Covered Services provided by a Professional Provider and/or Facility Provider for:

   a. Orthognathic surgery – surgery on the bones of the jaw (maxilla or mandible) to correct their position and/or structure for the following clinical indications only:

      (1) The initial treatment of Accidental Injury/trauma (i.e. fractured facial bones and fractured jaws), in order to restore proper function.

      (2) In cases where it is documented that a severe congenital defect (i.e., cleft palate) results in speech difficulties that have not responded to non-surgical interventions.

      (3) In cases where it is documented (using objective measurements) that chewing or breathing function is materially compromised (defined as greater than two standard deviations from normal) where such compromise is not amenable to non-surgical treatments, and where it is shown that orthognathic surgery will decrease airway resistance, improve breathing, or restore swallowing.

   b. Other oral surgery – defined as surgery on or involving the teeth, mouth, tongue, lips, gums and contiguous structures. Benefits will be provided only for:

      (1) Surgical removal of impacted teeth which are partially or completely covered by bone.

      (2) The surgical treatment of cysts, infections, and tumors performed on the structures of the mouth; and

      (3) Surgical removal of teeth prior to cardiac surgery, radiation therapy or organ transplantation.

3. **Assistant at Surgery**

Services for a Covered Person by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery.

The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Claims Administrator. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

4. **Anesthesia**

Administration of Anesthesia in connection with the performance of Covered Services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider.

5. **Second Surgical Opinion (Voluntary)**

Consultations for Surgery to determine the Medical Necessity of an elective surgical procedure. Elective Surgery is that Surgery which is not of an emergency or life threatening nature.

Such Covered Services must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery.

One additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation.

In such instances the Covered Person will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

G. TRANSPLANT SERVICES

When a Covered Person is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all Inpatient and Outpatient transplants which are beyond the Experimental or Investigative stage.

Inpatient and Outpatient transplants require pre-certification with the following exceptions: transplantation of cornea or skin. Benefits are also provided for those services to the Covered Person which are directly and specifically related to the covered transplantation. This includes services for the examination of such transplanted organs, marrow or tissue and the processing of Blood provided to a Covered Person.

(a) When both the recipient and the donor are Covered Persons, each is entitled to the benefits of this coverage. Benefits for the donor will be charged against the recipient's coverage under this coverage.

(b) When only the recipient is a Covered Person, only the recipient is entitled to this coverage.

(c) When only the donor is a Covered Person, the donor is not entitled to the benefits of this coverage.

(d) If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue.

Failure to precertify Inpatient transplants will result in a $1,000 reduction in benefits payable for these services.

Failure to precertify Outpatient transplants will result in a 20% reduction in benefits payable for these services.

OUTPATIENT BENEFITS

A Covered Person is entitled to benefits for Covered Services on an Outpatient basis when deemed Medically Appropriate/Medically Necessary and billed for by a Provider. Payment allowances for Covered Services and any Precertification and other cost-sharing requirements are specified in the Schedule of Benefits.

A. AMBULANCE

Ambulance services, which are Medically Appropriate/Medically Necessary as determined by the Claims Administrator, for local transportation in a specially designed and equipped vehicle used only to transport the sick or injured are a Covered Expense. All Non-Preferred, non-emergency ambulance services must be pre-certified in accordance with the provisions set forth in the Managed Care section of this booklet.

The Ambulance must be transporting the Covered Person:

a. from a Covered Person's home or the scene of an accident or Medical Emergency to the nearest Hospital;

b. between Hospital and Skilled Nursing Facility or between Hospitals.

c. If there is no Hospital in the local area that can provide services Medically Appropriate/Medically Necessary for the Covered Person's condition, then ambulance service means transportation to the closest Hospital outside the local area that can provide the necessary service.

d. Air or sea ambulance transportation benefits are payable only if the Claims Administrator determines that the patient's condition, and the distance to the nearest facility able to treat the patient's condition, justify the use of air instead of another means of transportation.

Failure to precertify Non-Emergency services will result in a 20% reduction in benefits payable for these services.

B. DAY REHABILITATION PROGRAM

Subject to the limits shown in the Schedule of Benefits, benefits will be provided for a Medically Appropriate/Medically Necessary Day Rehabilitation Program when provided by a Facility Provider under the following conditions:

1. The Covered Person requires intensive Therapy services, such as Physical, Occupational and/or Speech Therapy five (5) days per week for 4-7 hours per day;

2. The Covered Person has the ability to communicate (verbally or non-verbally) his/her needs; the ability to consistently follow directions and to manage his/her own behavior with minimal to moderate intervention by professional staff;

3. The Covered Person is willing to participate in a Day Rehabilitation Program; and

4. The Covered Person’s family must be able to provide adequate support and assistance in the home and must demonstrate the ability to continue the rehabilitation program in the home.

C. DIABETIC EDUCATION PROGRAM

Benefits are provided for diabetes Outpatient self-management training and education, including medical nutrition, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when prescribed by a Professional Provider legally authorized to prescribe such items under law.

The attending Physician must certify that a Covered Person requires diabetic education on an Outpatient basis under the following circumstances: (1) upon the initial diagnosis of diabetes; (2) a significant change in

the patient's symptoms or condition; or (3) the introduction of new medication or a therapeutic process in the treatment or management of the patient's symptoms or condition.

Outpatient diabetic education services will be covered when provided by a Preferred Facility Provider or a Preferred Ancillary Provider. The diabetic education program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Claims Administrator. These requirements are based on the certification programs for outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.

Covered services include Outpatient sessions that include, but may not be limited to, the following information:

1. initial assessment of the patient's needs;
2. family involvement and/or social support;
3. psychological adjustment for the patient;
4. general facts/overview on diabetes;
5. nutrition including its impact on blood glucose levels;
6. exercise and activity;
7. medications;
8. monitoring and use of the monitoring results;
9. prevention and treatment of complications for chronic diabetes, (i.e., foot, skin and eye care);
10. use of community resources; and
11. pregnancy and gestational diabetes, if applicable.

D. DIABETIC EQUIPMENT AND SUPPLIES

Benefits shall be provided, subject to any applicable Deductible, Copayment and/or Coinsurance or precertification requirements applicable to Durable Medical Equipment benefits

1. Diabetic Equipment

    a. blood glucose monitors*;
    b. insulin pumps*;
    c. insulin infusion devices*; and
    d. orthotics and podiatric appliances for the prevention of complications associated wit diabetes*.

*Precertification is required for the purchase of equipment that exceeds $500 of the billed amount. The applicable Deductible, Copayment and/or Coinsurance amounts will apply to this benefit.

2. Diabetic Supplies

    Insulin, oral agents and other Diabetic Supplies are covered under the Fund's free-standing prescription drug program.

E. DIAGNOSTIC SERVICES

The following Diagnostic Services when ordered by a Professional Provider and billed by a Professional Provider, and/or a Facility Provider:

a. Diagnostic X-ray, consisting of radiology, ultrasound, and nuclear medicine;

b. Diagnostic laboratory and pathology tests.

c. Diagnostic medical procedures consisting of ECG, EEG, and other diagnostic medical procedures approved by the Claims Administrator.

d. Allergy testing, consisting of percutaneous, intracutaneous and patch tests.

Preprocedure certification is required for the following diagnostic procedures: Preferred and Non-Preferred Operative and Diagnostic Endoscopies, MRI, MRA, CAT Scan and PET Scan, as described in the Managed Care Section. Failure to precertify Non-Preferred Services will result in a 20% reduction in benefits.

The Claims Administrator reserves the right to modify the diagnostic procedures that are subject to precertification after written notice has been given to the Fund.

F. DURABLE MEDICAL EQUIPMENT

Precertification is required on the rental of any Durable Medical Equipment and the purchase of all Durable Medical Equipment that exceed the amount shown on the Schedule of Benefits.

Durable Medical Equipment

Benefits will be provided for the rental (but not to exceed the total allowance of purchase) or, at the option of the Claims Administrator, the purchase of Durable Medical Equipment when prescribed by a Professional Provider and required for therapeutic use, when determined to be Medically Appropriate/Medically Necessary by the Claims Administrator.

Although an item may be classified as Durable Medical Equipment, it may not be covered in every instance. Therefore, precertification is required on the rental of any Durable Medical Equipment and the purchase of all Durable Medical Equipment that exceeds the amount shown in the Schedule of Benefits.

Durable Medical Equipment, as defined in the "Defined Terms" section of this booklet, includes equipment that meets the criteria of (a) – (d) below.

(a) It is durable and can withstand repeated use. An item is considered durable if it can withstand repeated use, i.e., the type of item that could normally be rented. Medical supplies of an expendable nature are not considered "durable". (For examples, see (d) under "Exclusions" below).

(b) It customarily and primarily serves a medical purpose.

(c) It is generally not useful to a person without an illness or injury. The item must be expected to make a meaningful contribution to the treatment of the patient's illness, injury, or to the improvement of a malformed body part.

(d) It is appropriate for home use.

Orthotics, when prescribed as Medically Necessary/Medically Appropriate, are covered with the limitations set forth in the Summary of Benefits Schedule

Exclusions:

Examples of equipment that do not meet the definition of Durable Medical Equipment include, but are not limited to:

(a) Comfort and convenience items, such as massage devices, portable whirlpool pumps, telephone alert systems; bed-wetting alarms; and ramps;

(b) Equipment used for environmental control, such as air cleaners, air conditioners, dehumidifiers, portable room heaters, and heating and cooling plants;

(c) Equipment inappropriate for home use. This is an item that generally requires professional supervision for proper operation, such as diathermy machines, medcolator, pulse tachometer, data transmission devices used for telemedicine purposes, translift chairs and traction units;

(d) Non-reusable supplies other than a supply that is an integral part of the DME item required for the DME function. This means the equipment (i) is not durable or (ii) is not a component of the DME. Items not

covered include, but are not limited to: incontinence pads, lambs wool pads, ace bandages, antiembolism stockings; catheters (non-urinary), face masks (surgical), disposable gloves, disposable sheets and bags, and irrigating kits;

(e) Equipment that is not primarily medical in nature. Equipment which is primarily and customarily used for a non-medical purpose may or may not be considered “medical” in nature. This is true even though the item may have some medically related use. Such items include but are not limited to ear plugs, exercise equipment, ice pack, speech teaching machines, strollers, feeding chairs, silverware/utensils; toileting systems; electronically-controlled heating and cooling units for pain relief; toilet seats; bathtub lifts; stairglides; and elevators.

(f) Equipment with features of a medical nature which are not required by the patient’s condition, such as a gait trainer. The therapeutic benefits of the item cannot be clearly disproportionate to its cost, if there exists a Medically Appropriate/Medically Necessary and realistically feasible alternative item that serves essentially the same purpose.

(g) Duplicate equipment for use when traveling or for an additional residence, whether or not prescribed by a Professional Provider;

(h) Services not primarily billed for by a Provider such as delivery, set-up and service activities and installation and labor of rented or purchased equipment; and

(i) Modifications to vehicles, dwellings and other structures. This includes (I) any modifications made to a vehicle, dwelling or other structure to accommodate a person’s disability; or (ii) any modification made to a vehicle, dwelling or other structure to accommodate a DME item, such as a wheelchair.

Replacement and Repair: The Claims Administrator will provide benefits for the replacement of Durable Medical Equipment: (a) when there has been a change in the Covered Person’s condition that requires the replacement, (b) if the equipment breaks because it is defective, or (c) it breaks because it has exceeded its life expectancy, as determined by the manufacturer. If an item breaks and is under warranty, unless it is a rental item, it is the responsibility of the Covered Person to work with the manufacturer to replace or repair it.

The Claims Administrator will provide benefits to repair Durable Medical Equipment when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of Durable Medical Equipment, replacement means the removal and substitution of Durable Medical Equipment or one of its components necessary for proper functioning. A repair is a restoration of the Durable Medical Equipment or one of its components to correct problems due to wear or damage. The Claims Administrator will not provide benefits for repairs and replacements needed because the equipment was abused or misplaced.

G. EMERGENCY CARE SERVICES

Benefits for Emergency Care Services provided by a Hospital Emergency Room or other Outpatient Emergency Facility within two days of the Emergency are provided by the Claims Administrator at the Preferred level of benefits, regardless of whether the patient is treated by a Preferred or Non-Preferred Provider. If Emergency Services are required, whether the Covered Person is located in or outside the PPO Network service area, call 911 or seek treatment immediately at the emergency department of the closest Hospital or Outpatient Emergency Facility.

Emergency Care services are Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for initial treatment of the Emergency. Outpatient follow-up care provided in a Medically Appropriate/Medically Necessary setting (in Emergency Room, other Outpatient Emergency Facility or physician’s office) are also covered if received within 14 days of the initial Outpatient Emergency Care, as specified above.

Examples of an Emergency include heart attack, loss of consciousness or respiration, cardiovascular accident, convulsions, severe Accidental Injury, and other acute medical conditions as determined by the Claims Administrator. Should any dispute arise as to whether an Emergency existed or as to the duration of an emergency, the determination by the Claims Administrator shall be final.

H. HOME HEALTH CARE

Benefits will be provided for the services listed below when performed by a licensed Home Health Care Agency. Home Health Care services must be pre-certified in accordance with the provisions set forth in the Managed Care section of this booklet.

- Professional services of appropriately licensed and certified individuals;
- Intermittent Skilled Nursing Care;
- Physical Therapy;
- Speech Therapy;
- Well mother/well baby care following release from an inpatient maternity stay.
- Care within 48 hours following release from an Inpatient admission when the discharge occurs within 48 hours following a mastectomy.

With respect to well mother/well baby care following early release from an inpatient maternity stay, Home Health Care services must be provided within 48 hours if discharge occurs earlier than 48 hours of a vaginal delivery or 96 hours of a cesarean delivery. No Deductible, Copayment or Coinsurance shall apply to these benefits when they are provided after an early discharge from the inpatient maternity stay.

Benefits are also provided for certain other medical services and supplies when provided along with a primary service. Such other services and supplies include occupational therapy, medical social services, home health aides in conjunction with skilled services and other services which may be approved by the Claims Administrator.

Home health care benefits will be provided only when prescribed by the Covered Person's attending Physician in a written Plan of Treatment and approved by the Claims Administrator as Medically Appropriate/Medically Necessary.

HOME – means a Covered Person's place of residence (e.g. private residence/domicile, assisted living facility, long-term care facility, skilled nursing facility (SNF)) at a custodial level of care.

HOMEBOUND – means there exists a normal inability to leave Home due to severe restrictions on the Covered Person's mobility and when leaving the Home: (a) would involve a considerable and taxing effort by the Covered Person; and (b) the Covered Person is unable to use transportation without another's assistance. A child, unlicensed driver or an individual who cannot drive will not automatically be considered Homebound but must meet both requirements (a) and (b).

Precertification must be performed in accordance with the Managed Care section of the booklet. Failure to precertify these services will result in a 20% reduction in benefits payable.

There is no requirement that the Covered Person be previously confined in a Hospital or Skilled Nursing Facility prior to receiving home health care.

With the exception of home health care provided to a Covered Person immediately following an Inpatient release for maternity care, the Covered Person must be homebound in order to be eligible to receive home health care benefits. This means that leaving the home could be harmful to such person, would involve a considerable and taxing effort, and that the Covered Person is unable to use transportation without another's assistance.

EXCLUSIONS

No Home Health Care benefits will be provided for services and supplies in connection with home health services for the following:

- custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
- rental or purchase of Durable Medical Equipment;

- rental or purchase of medical appliances (e.g. braces) and prosthetic devices (e.g., artificial limbs); supportive environmental materials and equipment, such as handrails, ramps, telephones, air conditioners and similar services, appliances and devices;
- prescription drugs;
- services provided by a member of the patient's Immediate Family or the Immediate family of the patient's spouse;
- patient's transportation, including services provided by voluntary ambulance associations for which the patient is not obligated to pay;
- emergency or non-emergency Ambulance services;
- visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
- services provided to individuals (other than a Covered Person released from an inpatient maternity stay), who are not essentially homebound for medical reasons; and
- visits by any Provider personnel solely for the purpose of assessing an individual's condition and determining whether or not the individual requires and qualifies for home health services and will or will not be provided services by the Provider.

I. MEDICAL FOODS AND NUTRITIONAL FORMULAS

Benefits shall be payable for Medical Foods when provided for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. Coverage is provided when administered on an outpatient basis either orally or through a tube. Benefits are exempt from Deductible requirements.

Benefits are also payable for Nutritional Formulas when: (1) they are the sole source of nutrition for an individual (more than 75% of estimated basal caloric requirement) and the Nutritional Formula is given by way of a tube into the alimentary tract, or (2) the Nutritional Formula is the sole source of nutrition (more than 75% of estimated basal caloric requirement) for an infant or child suffering from Severe Systemic Protein Allergy, refractory to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.

Benefits are payable for Medical Foods and Nutritional Formulas when provided through a Durable Medical Equipment Supplier or in connection with Infusion Therapy as provided for in this coverage.

J. NON-SURGICAL DENTAL SERVICES

Benefits will be provided only for the initial treatment of Accidental Injury/trauma (i.e., fractured facial bones and fractured jaws), in order to restore proper function. Restoration of proper function includes the dental services required for the initial restoration or replacement of Sound, Natural Teeth, including the first caps, crowns, bridges and dentures (but not including dental implants), required for the initial treatment for the Accidental Injury/trauma. Also covered is the preparation of the jaws and gums required for initial replacement of Sound, Natural Teeth. (Sound, Natural Teeth are teeth that are stable, functional, free from decay and advanced periodontal disease, in good repair at the time of the Accidental injury/trauma). Injury as a result of chewing or biting is not considered an Accidental Injury. (See the exclusion of dental services in the What Is Not Covered section for more information on what dental services are not covered);

K. PRIVATE DUTY NURSING SERVICES

Benefits will be provided as specified in the Schedule of Benefits for Outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by a Physician. All nursing services must be Medically Appropriate/Medically Necessary as determined by the Claims Administrator and pre-certified in accordance with the provisions set forth in the Managed Care section of this booklet.

Benefits are not payable for:

(a) nursing care which is primarily custodial in nature; such as care that primarily consists of: bathing, feeding, exercising, homemaking, moving the patient, giving oral medication;

(b) services provided by a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's immediate family; and

(c) services provided by a home health aide or a nurse's aide.

L. PROSTHETICS

Expenses incurred for prosthetic devices (except dental prostheses) required as a result of illness or injury. Expenses for prosthetic devices are subject to medical review by the Claims Administrator to determine eligibility and Medical Appropriateness/Medical Necessity.

Such expenses may include, but not be limited to:

a. the purchase, fitting, necessary adjustments and repairs of prosthetic devices which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ; and

b. the supplies and replacement of parts necessary for the proper functioning of the prosthetic device;

c. breast prostheses required to replace the removed breast or portions thereof as a result of mastectomy and prosthetics inserted during reconstructive surgery incident and subsequent to mastectomy.

   Coverage limitations on external breast prostheses are as follows:

   (i) Post mastectomy, four bras per calendar year are covered;
   (ii) The useful lifetime expectancy for silicone breast prostheses is (2) two years ;
   (iii) The lifetime expectancy of fabric, foam or fiber-filled breast prostheses is (6) six months; and

d. Benefits are provided for the following visual Prosthetics when Medically Appropriate/Medically Necessary and prescribed for one of the following conditions:

   (1) Initial contact lenses prescribed for treatment of infantile glaucoma;
   (2) Initial pinhole glasses prescribed for use after surgery for detached retina;
   (3) Initial corneal or scleral lenses prescribed (i) in connection with the treatment of keratoconus; or (ii) to reduce a corneal irregularity other than astigmatism;
   (4) Initial scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
   (5) Initial pair of basic eyeglasses when prescribed to perform the function of a human lens (aphakia) lost as a result of (i) Accidental Injury; (ii) trauma, or (iii) ocular surgery.

   Benefits are not provided for

   (1) Lenses which do not require a prescription;
   (2) Any lens customization such as, but not limited to tinting, oversize or progressive lenses, antireflective coatings, UV lenses or coatings, scratch resistance coatings, mirror coatings, or polarization;
   (3) Deluxe frames;
   (4) Eyeglass accessories, such as cases, cleaning solution and equipment.

   The repair and replacement provisions do not apply to this item d.

Benefits are not payable for: (a) wigs (except for cranial prostheses for chemotherapy patients, limited to $450 per lifetime) or (b) eyeglasses except as specified in Item d. above.

Repair and Replacement

Benefits for replacement of a prosthetic device or its parts will be provided: (a) when there has been a significant change in the Covered Person’s medical condition that requires the replacement; (b) if the prostheses breaks because it is defective; (c) if the prostheses breaks because it has exceeded its life expectancy, as determined by the manufacturer; or (d) for a Dependent child due to the normal growth process when Medically Necessary.

The Claims Administrator will provide benefits to repair prosthetic devices when the cost to repair is less than the cost to replace it. For purposes of replacement or repair of a prostheses, replacement means the removal and substitution of the prostheses or one of its components necessary for proper functioning.

A repair is a restoration of the prostheses or one of its components to correct problems due to wear or damage. However, the Claims Administrator will not provide benefits for repairs and replacements needed because the prosthetic was abused or misplaced. If a prosthetic device breaks and is under warranty, it is the responsibility of the Covered Person to work with the manufacturer to replace or repair it.

M. RESTORATIVE SERVICES

Benefits shall be provided for Restorative Services, subject to the benefit period maximums set forth in the Schedule of Benefits, when performed by a Professional Provider in order to restore loss of function of a body part. Restorative Services are any services, other than those specifically detailed under “Therapy Services”, provided in accordance with a specific plan of treatment related to the Covered Person's condition which generally involve neuromuscular training as a course of treatments over weeks or months. Examples of Restorative Services include, but are not limited to, manipulative treatment of functional loss from back disorder, therapy treatment of functional loss following foot surgery, and orthoptic/pleoptic therapy.

N. SPECIALIST OFFICE VISIT

Benefits will be provided for Specialist Service medical care provided in the office by a Provider other than a Primary Care Physician. For the purpose of this benefit, “in the office” includes medical care visits to a Provider’s office, medical care visits by a Provider to a Covered Person’s residence, or medical care consultations by a Provider on an Outpatient basis.

O. THERAPY SERVICES

Benefits shall be provided, subject to the Benefit Period Maximums specified in the Schedule of Benefits, for the following services prescribed by a Physician and performed by a Professional Provider, a registered, licensed therapist, and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Covered Person.

Cardiac Rehabilitation Therapy

Refers to a medically supervised rehabilitation program designed to improve a patient’s tolerance for physical activity or exercise. Benefits are provided up to the number of visits specified in the Schedule of Benefits.

Chemotherapy

Chemotherapy means the treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetic and other related biotech products. Such chemotherapeutic agents are eligible if administered intravenously or intramuscularly (through intra-arterial injection, infusion, perfusion or subcutaneous, intracavitary and oral routes).

The cost of drugs, approved by the Federal Food and Drug Administration and only for those uses for which such drugs have been specifically approved by the Federal Food and Drug Administration (FDA) as antineoplastic agents is covered, provided they are administered as described in this paragraph.

Dialysis

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

Benefits will not be provided to the extent that benefits are payable by Medicare for persons who are Medicare eligible on the basis of end stage renal disease (ESRD) and for whom Medicare must pay as primary Claims Administrator.

Effective January 1, 2007, the second paragraph under “Dialysis” is removed.

Infusion Therapy

Treatment includes, but is not limited to, infusion or inhalation, parenteral and Enteral Nutrition, antibiotic therapy, pain management and hydration therapy.

Occupational Therapy

Includes treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. Coverage will also include services rendered by a registered, licensed occupational therapist. Benefits are provided up to the number of visits specified in the Schedule of Benefits.

Physical Therapy

Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.

Pulmonary Rehabilitation Therapy

Includes treatment through a multidisciplinary program which combines Physical Therapy with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status for Chronic Obstructive Pulmonary Disease (COPD). COPD may include, but is not limited to, diagnosis such as emphysema, chronic bronchitis, asthmatic bronchitis, pre-lung transplant and cystic fibrosis. Benefits are provided up to the number of sessions specified in the Schedule of Benefits.

Radiation Therapy

The treatment of disease by X-ray, radium, or radioactive isotopes, or other radioactive substances regardless of the method of delivery, including the cost of radioactive materials supplied and billed by the Provider.

Respiratory Therapy

Includes the introduction of dry or moist gases into the lungs for treatment purposes. Coverage will also include services by a respiratory therapist.

Speech Therapy

Includes treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital anomalies, or previous therapeutic processes. Coverage will also include services by a speech therapist.

Preprocedure certification is required for the Infusion Therapy Services as described in the Managed Care section of this booklet. Failure to precertify these services will result in a 20% reduction in benefits payable for these services.

WHAT IS NOT COVERED

Except as specifically provided in this booklet, no benefits will be provided for services, supplies or charges:

- Which are not Medically Appropriate/Medically Necessary as determined by the Claims Administrator for the diagnosis or treatment of illness or injury;
- Which are Experimental/Investigational, except, as approved by the Claims Administrator, Routine Costs associated with a Qualifying Clinical Trial that meets the definition of a Qualifying Clinical Trial under this coverage;
- Which were Incurred prior to the Covered Person's Effective Date of coverage;
- Which were or are Incurred after the date of termination of the Covered Person's coverage except as provided in the General Information section of this booklet;
- For any loss sustained or expenses Incurred during military service while on active duty; or as a result of enemy action or act of war, whether declared or undeclared.
- For which a Covered Person would have no legal obligation to pay;
- Received from a dental or medical department maintained by or on behalf of a Fund, a mutual benefit association, labor union, trust, or similar person or Fund;
- Paid or payable by Medicare when Medicare is primary. For purposes of this Plan, a service, supply or charge is “payable under Medicare” when the Covered Person is eligible to enroll for Medicare benefits, regardless of whether the Covered Person actually enrolls for, pays applicable premium for, maintains, claims or receives Medicare benefits;
- For any occupational illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation;
- To the extent benefits are provided by the Veteran's Administration or by the Department of Defense for members of the armed forces of any nation while on active duty;
- For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
- For drugs or medicines for which the Covered Person has coverage under a free-standing prescription drug program provided through the Enrolled Fund;
- Which are not billed and performed by a Provider as defined under this coverage as a “Professional Provider” “Facility Provider” or “Ancillary Provider” except as otherwise indicated under the subsections entitled: (a) "Therapy Services" (that identifies covered therapy services as provided by licensed therapists), and (b) "Ambulance Services", as described under section entitled **“PREFERRED PROVIDER NETWORK PROGRAM BENEFITS”**;
- Rendered by a member of the Covered Person's Immediate Family;
- Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a hospital or university;
- For ambulance services except as specifically provided under this coverage;
- For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected. However, benefits are

payable to correct a condition resulting from an accident. Benefits are also payable to correct functional impairment which results from a covered disease, injury or congenital birth defect. This exclusion does not apply to mastectomy related charges as provided for and defined in the subsection entitled SURGICAL SERVICES in the Your Preferred Provider Organization Benefits section of this booklet;

- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;

- For marriage counseling;

- For Custodial Care, domiciliary care or rest cures;

- For equipment costs related to services performed on high cost technological equipment as defined by the Claims Administrator, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or by the Claims Administrator;

- For dental services related to the care, filling, removal or replacement of teeth (including dental implants to replace teeth or to treat congenital anodontia, ectodermal dysplasis or dentinogenesis imperfecta), and the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as otherwise specifically stated in this booklet. Services not covered include, but are not limited to, apicoectomy (dental root resection) prophylaxis of any kind, root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants; and treatment of periodontal disease unless otherwise indicated;

- For dental implants for any reason;

- For dentures, unless for the initial treatment of an Accidental Injury/trauma;

- For orthodontic treatment, except for appliances used for palatal expansion to treat congenital cleft palate;

- For injury as a result of chewing or biting (neither is considered an Accidental Injury); o For treatment of temporomandibular joint syndrome(TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension;

- For palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone Surgery), calluses, toe nails (except Surgery for ingrown nails), fallen arches, pes planus (flat feet), weak feet, chronic foot strain, and symptomatic complaints of the feet;

- For supportive devices of the foot, except for orthotic appliances that are covered as set forth in the Summary of Benefits Schedule;

- For Hearing Aids, including cochlear electromagnetic hearing devices and/or implants, and hearing examinations or tests for the prescription or fitting of Hearing Aids. Services and supplies related to these items are not covered;

- For any treatment leading to or in connection with transsexual Surgery except for sickness or injury resulting from such surgery;

- For assisted fertilization techniques such as, but not limited to, artificial insemination, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);

- For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury;

- For treatment of obesity, except for surgical treatment of obesity when: (a) the Claims Administrator determines the surgery is Medically Appropriate/Medically Necessary, and (b) the surgery is not a repeat, reversal or revision of any previous obesity surgery. The exclusion of coverage for a repeat, reversal or

revision of a previous obesity surgery does not apply when the procedure is required to treat complications, which if left untreated, would result in endangering the health of the Covered Person;

- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness or exercise equipment, radio and television, beauty/barber shop services, guest trays, wigs (except for cranial prostheses for chemotherapy patients, as set forth in this booklet), chairlifts, stairglides, elevators, spa or health club memberships, whirlpool, sauna, hot tub or equivalent device, whether or not recommended by a Provider;

- For wigs (except for cranial prostheses for chemotherapy patients, as set forth in this booklet);

- For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses unless otherwise indicated;

- For correction of myopia or hyperopia by means of corneal microsurgery, such as Lasik, keratomileusis, keratophakia, and radial keratotomy and all related services;

- For preventive services except as specifically provided for under the subsection entitled "Primary and Preventive Care Services" of the Your Preferred Provider Organization Benefits section of this booklet;

- For weight reduction;

- For premarital blood tests;

- For diagnostic screening examinations, except for mammograms and preventive care as provided in the subsection entitled "Primary and Preventive Care Services" of Your Preferred Provider Organization Benefits section of this booklet;

- For Alternative Therapies/complementary medicine, including but not limited to, acupuncture, music therapy, dance therapy, equestrian/hippotherapy, homeopathy, primal therapy, rolfing, psychodrama, vitamin or other dietary supplements and therapy, naturopathy, hypnotherapy, bioenergetic therapy, Qi Gong, Ayurvedic therapy, aromatherapy, massage therapy, therapeutic touch, recreational, wilderness, educational and sleep therapies;

- For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider;

- For immunizations required for employment purposes, or for travel;

- For care in a nursing home, home for the aged, convalescent home, school, institution for retarded children, Custodial Care in a Skilled Nursing Facility;

- For counseling or consultation with a patient’s relatives or Hospital charges for a patient’s relatives or guests;

- For medical supplies such as but not limited to thermometers, ovulation kits, and early pregnancy or home pregnancy testing kits;

- For home blood pressure machines, except for Covered Persons: (a) with pregnancy-induced hypertension, (b) with hypertension complicated by pregnancy, and (c) with end-stage renal disease receiving home dialysis;

- As described under “Durable Medical Equipment” in the Your Preferred Provider Organization Benefits section of this booklet: for personal hygiene, comfort and convenience items; equipment and devices of a primarily nonmedical nature; equipment inappropriate for home use; equipment containing features of a medical nature that are not required by the patient’s condition; non-reusable supplies; equipment which cannot reasonably be expected to serve a therapeutic purpose; duplicate equipment, whether or not rented or purchased as a convenience; devices and equipment used for environmental control; and customized wheelchairs;

- For prescription drugs;
- For amino acid supplements, appetite suppressants or nutritional supplements. Coverage does not include basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy. This exclusion does not apply to Medical Foods and Nutritional Formulas as provided for and defined in the subsection entitled "Medical Foods and Nutritional Formulas" in the section entitled Your Preferred Provider Organization Benefits;
- For Inpatient Private Duty Nursing services;
- For any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Development Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, or mental retardation; or treatment or care to effect environmental or social change;
- For charges incurred for expenses in excess of Benefit Maximums as specified in the Schedule of Benefits;
- For research studies;
- For Maintenance of chronic conditions;
- For Cognitive Rehabilitation Therapy; (Cognitive Rehabilitation Therapy is a therapeutic approach designed to improve cognitive functioning after central nervous system injury or trauma. It includes therapy methods that retrain or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning and problem solving. It utilizes tasks designed to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for the impaired neurologic system);
- For elective abortions, except (a) to avert the death of the mother, and (b) to terminate a pregnancy that is the result of either rape or incest;
- For maternity benefits for dependent daughters, except for treatment of complications of pregnancy as defined in this booklet;
- For the reversal of sterilization;
- For transplant donor services, except if both the donor and the recipient are members of the Fund or, if the donor is not a member of the Fund, in excess of $25,000 per transplant of secondary coverage;
- For mental health/psychiatric services and treatment for alcohol and drug abuse and dependency. (These services may be covered under a separate program provided by the Fund);
- For oral and implantable contraceptive drugs and devices, except when prescribed to treat certain medical conditions.
- For penile prosthetic devices; and
- For any other service or treatment except as provided under the coverage.

GENERAL INFORMATION

BENEFITS TO WHICH YOU ARE ENTITLED

The liability of the Claims Administrator is limited to the benefits specified in this booklet. The Claims Administrator's determination of the benefit provisions applicable for the services rendered to you shall be conclusive.

TERMINATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP IN THE FUND

When a Covered Person ceases to be an Eligible Member or Eligible Dependent, or the required contribution is not paid, the Covered Person's coverage will terminate at the end of the last month for which payment was made. However, if benefits under this coverage are provided by and/or approved by the Claims Administrator before the Claims Administrator receives notice of the Covered Person’s termination under the Fund Contract, the cost of such benefits will be the sole responsibility of the Covered Person. In that circumstance, the Claims Administrator will consider the effective date of termination of a Covered Person under the Fund Contract to be not more than 60 days before the first day of the month in which the Fund notified the Claims Administrator of such termination.

CONTINUATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP DUE TO TOTAL DISABILITY

Your protection under this coverage may be extended after the date you cease to be a Covered Person under the coverage because of termination of employment or termination of membership in the Fund. It will be extended if, on that date, you are totally disabled from an illness or injury. The extension is only for that illness or injury and any related illness or injury. It will be for the time you remain Totally Disabled from any such illness or injury, but not beyond three months if you cease to be a Covered Person because your coverage under the Fund Contract ends.

Coverage under this Plan will apply during an extension as if you were still a Covered Person, except any reinstatement of your Lifetime Maximum amount will not be allowed under the Reinstatement subsection as set forth in the Schedule of Benefits section of this booklet. In addition, coverage will apply only to the extent that other coverage for the Covered Services is not provided for you though the Claims Administrator by the Fund. Continuation of coverage is subject to payment of the applicable premium.

CONTINUATION OF INCAPACITATED CHILD

If an unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on you for over half of his support, you may apply to the Claims Administrator to continue coverage of such child under the Claims Administrator upon such terms and conditions as the Claims Administrator may determine. Coverage of such Dependent child shall terminate upon his or her marriage. Continuation of benefits under this provision will only apply if the child was eligible as a dependent and mental or physical incapacity commenced prior to age 19, or if such mental or physical incapacity occurred after age 19 while the child was covered as a full-time student.

The child must be unmarried, incapable of self-support and the disability must have commenced prior to attaining 19 years of age. The disability must be certified by the attending physician; furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over 19 years of age and joining the Claims Administrator for the first time, the handicapped child must have been covered under the prior Claims Administrator and submit proof from the prior Claims Administrator that the child was covered as a handicapped person.

WHEN YOU TERMINATE EMPLOYMENT - CONTINUATION OF COVERAGE PROVISIONS – COBRA

For purposes of this subsection of your booklet, A “qualified beneficiary” means any person who, on the day before any event which would qualify him or her for continuation under this subsection, is covered for Fund health benefits under this Plan as:

a. you, an active, covered Member;

b. your spouse; or
c. your Dependent child.

In addition, any child born to or placed for adoption with you during COBRA continuation will be a qualified beneficiary.

Any person who becomes covered under this Plan during COBRA continuation, other than a child born to or placed for adoption with you during COBRA continuation, will not be a qualified beneficiary.

If a Member Terminates Employment or Has a Reduction of Work Hours: If your group benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if:

a. your termination of employment was not due to gross misconduct; and
b. you are not entitled to Medicare.

The continuation will cover you and any other qualified beneficiary who loses coverage because of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, subject to the 'When Continuation Ends' paragraph of this subsection.

Extra Continuation for Disabled Qualified Beneficiaries: If a qualified beneficiary is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the day before the qualified beneficiary's health benefits would otherwise end due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours or within 60 days of that date, the qualified beneficiary and any other affected qualified beneficiaries may elect to extend the 18 month continuation period described above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Plan Administrator must be given written proof of Social Security's determination of the qualified beneficiary's disability before the earlier of:

a. The end of the 18 month continuation period; and
b. 60 days after the date the qualified beneficiary is determined to be disabled.

If, during the 11 month continuation period, the qualified beneficiary is determined to be no longer disabled under the United States Social Security Act, the qualified beneficiary must notify the Plan Administrator within 30 days of such determination, and continuation will end, as explained in the "When Continuation Ends' paragraph of this subsection.

If a Member Dies: If you die, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the 'When Continuation Ends' paragraph of this subsection.

If a Member's Marriage Ends: If your marriage ends due to divorce or if you and your spouse become separated, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the 'When Continuation Ends' paragraph of this subsection.

If a Member Becomes Entitled to Medicare: If you become entitled to Medicare after terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months from the date the initial 18 month continuation period started, subject to the 'When Continuation Ends' paragraph of this subsection.

If you become entitled to Medicare **before** terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours and, during the subsequent 18-month period, you terminate employment (for reasons other than gross misconduct) or have a reduction of work hours, all qualified beneficiaries other than you whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 18 months, but may be extended until 36 months from the date you became entitled to Medicare, subject to the 'When Continuation Ends' paragraph of this subsection.

If a Dependent Loses Eligibility: If your Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this booklet, other than your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified beneficiary. The continuation can last for up to 36 months, subject to the 'When Continuation Ends' paragraph of this subsection.

Concurrent Continuations: If your Dependent who is a qualified beneficiary elects to continue his or her group health benefits due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above.

The 36 month continuation period starts on the date the initial 18 month continuation period started, and the two continuation periods will run concurrently.

The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this subsection must notify the Plan Administrator, in writing, of:

a. your divorce or separation from your spouse;
b. your Dependent child's loss of dependent eligibility, as defined in this booklet; or
c. Social Security Administration's determination of disability.

The notice must be given to the Plan Administrator within 60 days of any of these events.

In addition, a disabled qualified beneficiary must notify the Plan Administrator, in writing, of any final determination that the qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act. The notice must be given to the Plan Administrator within 30 days of such final determination.

The Fund's Responsibilities: Your Fund must notify the Plan Administrator, in writing, of:

a. your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
b. your death;
c. your entitlement to Medicare; or
d. commencement of employer's bankruptcy proceedings.

The notice must be given to the Plan Administrator no later than 30 days of any of these events.

The Plan Administrator's Responsibilities: The Plan Administrator must notify the qualified beneficiary, in writing, of:

a. his or her right to continue the group health benefits described in this booklet;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified beneficiary within 14 days of:

a. the date the qualified beneficiary notifies the Plan Administrator, in writing, of your divorce or separation from your spouse, or your Dependent child's loss of eligibility; or
b. the date the Fund notifies the Plan Administrator, in writing, of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, your death, or your entitlement to Medicare;

The Fund's Liability: Your Fund will be liable for the qualified beneficiary's continued group health benefits to the same extent as, and in the place of, the Plan, if:

a. the Fund fails to remit a qualified beneficiary's timely premium payment to the Plan on time, thereby causing the qualified beneficiary's group health benefit to end; or

b. the Plan Administrator fails to notify the qualified beneficiary of his or her continuation rights, as described above.

Election of Continuation: To continue his or her group health benefits, the qualified beneficiary must give the Plan Administrator written notice that he or she elects to continue benefits under the coverage. This must be done within 60 days of the date a qualified beneficiary receives notice of his or her continuation rights from the Plan Administrator as described above or 60 days of the date the qualified beneficiary's group health benefits end, if later. Furthermore, the qualified beneficiary must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Plan Administrator by the qualified beneficiary, in advance, at the time and in the manner set forth by the Plan Administrator. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified beneficiary stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the Fund. An additional charge of two percent of the total premium charge may also be required by the Fund.

Qualified beneficiaries who receive the extended coverage due to disability described above may be charged an additional 50% of the total premium charge during the extra 11 month continuation period.

If the qualified beneficiary fails to give the Plan Administrator notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment in Premiums: A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, the premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends: A qualified beneficiary's continued group health benefits under this coverage ends on the first to occur of the following:

a. with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

b. with respect to a disabled qualified beneficiary and his or her family members who are qualified beneficiaries who have elected an additional 11 months of continuation, the earlier of:

    i the end of the 29 month period which starts on the date the group health benefits would otherwise end;

    or

    ii the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified beneficiary is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c. with respect to continuation upon your death, your divorce or separation, or the end of your covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

d. with respect to your Dependent whose continuation is extended due to your entitlement to Medicare,

    i after, your termination of employment or reduction of work hours, the end of the 36 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours; and

    ii before, your termination of employment or reduction of work hours where, during the 18-month period following Medicare entitlement, you terminate employment or have a reduction of work hours, at least to the end of the 18 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours, but not less than 36 months from the date you become entitled to Medicare.

e. the date this coverage ends;

f. the end of the period for which the last premium payment is made;

g. the date he or she becomes covered under any other group health plan (as a Member or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified beneficiary other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;

h. the date he or she becomes entitled to Medicare.

THE CLAIMS ADMINISTRATOR'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS COVERAGE ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF YOUR BOOKLET.

THE CLAIMS ADMINISTRATOR IS NOT THE PLAN ADMINISTRATOR UNDER THE COVERAGE OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE FUND.

RELEASE OF INFORMATION

Each Covered Person agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this Plan may furnish to the Claims Administrator, upon its request, any information (including copies of records relating to the illness or injury).

In addition, the Claims Administrator may furnish similar information to other entities providing similar benefits at their request.

The Claims Administrator shall provide to the Fund at the Fund's request certain information regarding claims and charges submitted to the Claims Administrator. The parties understand that any information provided to the Fund will be adjusted by the Claims Administrator to prevent the disclosure of any information that is protected by applicable state or federal laws of any Member or other patient treated by said Providers. The Fund shall reimburse the Claims Administrator for the actual costs of preparing and providing said information.

The Claims Administrator may also furnish other plans or plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

When the Claims Administrator needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Covered Person who is unable to provide it, the Claims Administrator will obtain consent from the parent, legal guardian, next of kin, or other individual with appropriate legal authority to make decisions on behalf of the Covered Person.

CONSUMER RIGHTS

Each Covered Person has the right to access, review and copy their own health and membership records and request amendments to their records. This includes information pertaining to claim payments, payment methodology, reduction or denial, medical information secured from other agents, plans or providers.

For more information about accessing, reviewing or copying records, call Member Services at the toll-free number on your ID card.

LIMITATION OF ACTIONS

No legal action may be taken to recover benefits prior to 60 days after notice of claim has been given as specified above, and no such action may be taken later than two years after the date Covered Services are rendered.

CLAIM FORMS

The Claims Administrator will furnish to you or to the Fund Contractholder, for delivery to you, such claim forms as are required for filing proof of loss for Covered Services provided by Non-Preferred Providers.

TIMELY FILING

The Claims Administrator will not be liable under the coverage unless proper notice is furnished to the Claims Administrator that Covered Services have been rendered to a Covered Person. Written notice must be given within 20 days after completion of the Covered Services. The notice must include the date and information required by the Claims Administrator to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

Failure to give notice to the Claims Administrator within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Claims Administrator be required to accept notice more than two years after the end of the Benefit Period in which the Covered Services are rendered.

The above is not applicable to claims administered by Preferred Providers.

MEMBER/PROVIDER RELATIONSHIP

a. The choice of a Provider or choice of treatment by a Provider is solely yours.

b. The Claims Administrator does not furnish Covered Services but only makes payment for Covered Services received by persons covered under the Claims Administrator. The Claims Administrator is not liable for any act or omission of any Provider. The Claims Administrator has no responsibility for a Provider's failure or refusal to render Covered Services to a Covered Person.

SUBROGATION

In the event any service is provided or any payment is made to you or your covered Dependent under this Plan, the Claims Administrator shall be subrogated and succeed to your rights of recovery against any person, firm, corporation, or organization except against insurers on policies of insurance issued to and in your name. You or your covered Dependent shall execute and deliver such instruments and take such other reasonable action as the Claims Administrator may require to secure such rights. You or your covered Dependent may do nothing to prejudice the rights given the Claims Administrator without the Claims Administrator's consent.

You or your covered Dependent shall pay the Claims Administrator all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided or paid under this Claims Administrator and as permitted by law.

The Claims Administrator's right of subrogation shall be unenforceable when prohibited by law.

COORDINATION OF BENEFITS

This Plan's Coordination of Benefits provision is designed to conserve funds associated with health care.

1. **Definitions**

   In addition to the Definitions of this Plan for purposes of this Provision only:

   "Plan" shall mean any Fund arrangement providing health care benefits or Covered Services through:

   a) individual, Fund, (except hospital indemnity plans of less than $200), blanket (except student accident) or franchise insurance coverage;

   b) the Plan, health maintenance organization and other prepayment coverage;

   c) coverage under labor management trusted plans, union welfare plans, Fund organization plans, or Member benefit organization plans; and

   d) coverage under any tax supported or government program to the extent permitted by law.

2. **Determination of Benefits**

   Coordination of Benefits (COB) applies when a Member has health care coverage under any other group health care plan (Plan) for services covered under this Plan, or when the Member has coverage under any tax-supported or governmental program unless such program's benefits are, to the extent permitted by law, excess to those of any private insurance coverage. When COB applies, payments may be coordinated between HORIZON and the other Plan in order to avoid duplication of benefits.

   Benefits under this Plan will be provided in full when HORIZON benefits are primary, that is, when HORIZON determines benefits first. If another Plan is primary, HORIZON will provide benefits as described below.

   When a Member has group health care coverage under this Plan and another Plan, the following will apply to determine which coverage is primary:

   a) If the other Plan does not include rules for coordinating benefits, such other Plan will be primary.

b) If the other Plan includes rules for coordinating benefits:

   1) The Plan covering the patient other than as a Dependent shall be primary.

   2) The Plan covering the patient as a Dependent of the parent whose date of birth, excluding year of birth, occurs earlier in the calendar year shall be primary, unless the child's parents are separated or divorced and there is no joint custody agreement. If both parents have the same birthday, the Plan which covered the parent longer shall be primary. However, if the other Plan does not have the birthday rule as described herein, but instead has a rule based on the gender of the parent, and if as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall control unless the child's parents are separated or divorced.

   3) Except as provided in subparagraph (4) below, if the child's parents are separated or divorced and there is no joint custody agreement, benefits for the child are determined as follows:

      i) First, the Plan covering the child as a Dependent of the parent with custody;
      ii) then, the Plan of the spouse of the parent with custody of the child;
      iii) finally, the Plan of the parent not having custody of the child.

   4) When there is a court decree which establishes financial responsibility for the health care expenses of the Dependent child and the Plan covering the parent with such financial responsibility has actual knowledge of the court decree, benefits of that Plan are determined first.

   5) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above in 2 (b) (2).

c) The Plan covering the patient as a Member who is neither laid off nor retired (or as that Member's Dependent) is primary to a Plan which covers that patient as a laid off or retired Member (or as that Member's Dependent). However, if the other Plan does not have the rule described immediately above and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.

d) If none of the above rules apply, the Plan which covered the Member longer shall be primary.

3. **<u>Effect on Benefits</u>**

When the HORIZON Plan is secondary, the benefits under this Plan will be reduced so that HORIZON will pay no more than the difference, if any, between the benefits provided under the other Plan for services covered under this Plan and the total Covered Services provided to the Member. Benefits payable under another Plan include benefits that would have been payable had the claim been duly made under the other Plan. In no event will a HORIZON payment exceed the amount that would have been payable under this Plan if HORIZON benefits were primary.

When the benefits are reduced under the Primary plan because a Member does not comply with the Plan provision, or does not maximize benefits available under the Primary Plan, the amount of such reduction will not be considered an allowable benefit. Examples of such provisions are those related to second surgical opinion penalties, and penalties and increased coinsurance related to precertification of admissions and services, Preferred Provider arrangements and other cost-sharing features.

Certain facts are needed to apply COB. HORIZON has the right to decide which facts are needed. HORIZON may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which HORIZON deems necessary for such purposes. Any person claiming benefits under this Plan shall furnish to HORIZON such information as may be necessary to implement this provision. HORIZON, however, shall not be required to determine the existence of any other Plan or the amount of benefits payable under any such Plan, and the payment of benefits under this Plan shall be affected by the benefits that would be payable under any and all other Plans only to the extent that HORIZON is furnished with information relative to such other Plans.

Right of Recovery

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan, HORIZON 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 provided under this Plan and, to the extent of such payments, HORIZON shall be fully discharged from liability under this Plan.

Whenever payments have been made by HORIZON in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, HORIZON shall have the right to recover such payments to the extent of such excess from among one or more of the following, as HORIZON shall determine:

1. the person HORIZON has paid or for whom they have paid;

2. insurance companies; or

3. any other organizations.

You, on your own behalf and on behalf of your Dependents, shall, upon request, execute and deliver such instruments and papers as may be required and do whatever else is reasonably necessary to secure such rights to HORIZON.

MANAGED CARE

A. UTILIZATION REVIEW PROCESS

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

It is not practical to verify Medical Appropriateness/Medical Necessity on all procedures on all occasions; therefore, certain procedures may be determined by the Claims Administrator to be Medically Appropriate/Medically Necessary and automatically approved based on the accepted Medical Appropriateness/Medical Necessity of the procedure itself, the diagnosis reported or an agreement with the performing Provider. An example of such automatically approved services is an established list of services received in an emergency room which has been approved by the Claims Administrator based on the procedure meeting emergency criteria and the severity of diagnosis reported (e.g. rule out myocardial infarction, or major trauma). Other requested services, such as certain elective Inpatient or Outpatient procedures may be reviewed on a procedure specific or setting basis.

Utilization review generally includes several components which are based on when the review is performed. When the review is required before a service is performed it is called a Precertification review. Reviews occurring during a hospital stay are called a concurrent review, and those reviews occurring after services have been performed are called either retrospective or post-service reviews. The Claims Administrator follows applicable state and federally required standards for the timeframes in which such reviews are to be performed.

Generally, where a requested service is not automatically approved and must undergo Medical Appropriateness/Medical Necessity review, nurses perform the initial case review and evaluation for coverage approval using the Claims Administrator's Medical Policies, established guidelines and evidence-based clinical criteria and protocols; however only a Medical Director employed by the Claims Administrator may deny coverage for a procedure based on Medical Appropriateness/Medical Necessity. The evidence-based clinical protocols evaluate the Medical Appropriateness/Medical Necessity of specific procedures and the majority are computer-based. Information provided in support of the request is entered into the computer-based system and evaluated against the clinical protocols. Nurses apply applicable benefit plan policies and procedures, taking into consideration the individual Covered Person's condition and applying sound professional judgment. When the clinical criteria are not met, the given service request is referred to a Medical Director for further review for approval or denial. Independent medical consultants may also be engaged to provide clinical review of specific cases or for specific conditions. Should a procedure be denied for coverage based on lack of Medical Appropriateness/Medical Necessity, a letter is sent to the requesting Provider and Covered Person in accordance with applicable law.

The Claims Administrator's utilization review program encourages peer dialogue regarding coverage decisions based on Medical Appropriateness/Medical Necessity by providing physicians with direct access to the Claims Administrator's Medical Directors to discuss coverage of a case. Medical Directors and nurses are salaried, and contracted external physician and other professional consultants are compensated on a per case reviewed basis, regardless of the coverage determination. The Claims Administrator does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals which would encourage utilization review decisions that result in underutilization.

B. CLINICAL CRITERIA, GUIDELINES AND RESOURCES

The following guidelines, clinical criteria and other resources are used to help make Medically Appropriate/Medical Necessity coverage decisions:

Clinical Decision Support Criteria: Clinical Decision Support Criteria is an externally validated and computer-based system used to assist the Claims Administrator in determining Medical Appropriateness/Medical Necessity. This evidence-based, Clinical Decision Support Criteria is nationally recognized and validated. Using a model based on evaluating intensity of service and severity of illness, these criteria assist our clinical staff evaluating the Medical Appropriateness/Medical Necessity of coverage based on a Covered Person's specific clinical needs. Clinical Decision Support Criteria helps promote consistency in the Claims Administrator's plan determinations for similar medical issues and requests, and reduces practice variation among the Claims Administrator's clinical staff to minimize subjective decision-making.

Clinical Decision Support Criteria may be applied for Covered Services including but not limited to the following:

- Some elective surgeries-settings for Inpatient and Outpatient procedures (e.g., hysterectomy and sinus surgery).
- Inpatient hospitalizations
- Inpatient Rehabilitation
- Home Health
- Durable Medical Equipment
- Skilled Nursing Facility

Centers for Medicare and Medicaid Services (CMS) Guidelines: A set of guidelines adopted and published by CMS for coverage of services by Medicare for Medicare Covered Persons.

Horizon's Medical Policies: Horizon maintains an internally developed set of policies that document the coverage and conditions for certain medical/surgical procedures and ancillary services.

Covered Services for which Horizon's Medical Polices are applied include, but are not limited to:

- Ambulance
- Infusion
- Speech Therapy
- Occupational Therapy
- Durable Medical Equipment
- Review of potential cosmetic procedures

Horizon Internally Developed Guidelines: A set of guidelines developed specifically by HORIZON, as needed, with input by clinical experts based on accepted practice guidelines within the specific fields and reflecting Horizon Medical Policies for coverage.

C. DELEGATION OF UTILIZATION REVIEW ACTIVITIES AND CRITERIA

The Claims Administrator delegates some of its utilization review process to the Claims Administrator's affiliate. That affiliate is a state licensed utilization review entity and is responsible for the Claims Administrator's utilization review process. In certain instances, the Claims Administrator has delegated certain utilization review activities, including Precertification review, concurrent review, and case management, to other entities with an expertise in medical management of a certain membership population (such as, Neonates/premature infants) or type of benefit or service (such as radiology). In such instances, a formal delegation and oversight process is established in accordance with applicable law and nationally-recognized accreditation standards. In such cases, the delegate's utilization review criteria are generally used, with the Claims Administrator's approval.

D. PRECERTIFICATION REVIEW

When required, Precertification review evaluates the Medical Necessity, including the Medical Appropriateness of the setting, of proposed services for coverage under the Covered Person's benefit plan. Examples of these services include planned or elective inpatient admissions. For groups located in the PPO Network service area, Precertification review may be initiated by the Provider or the Covered Person depending on whether the Provider is a PPO Network Provider. For Covered Person's located outside the

Claims Administrator's PPO Network who are accessing BlueCard Providers, the Covered Person is responsible for initiating or requesting the Provider to initiate the Precertification review. Where Precertification review is required, the Claims Administrator's coverage of the proposed procedure is contingent upon the review being completed and receipt of the approval certification. Coverage penalties may be applied where Precertification review is required for a procedure but is not obtained.

While the majority of services requiring Precertification review are reviewed for Medical Appropriateness of the requested procedure setting (e.g., Inpatient, Short Procedure Unit, or Outpatient setting), other elements of the Medical Appropriateness/Medical Necessity of the procedure may not always be evaluated and may be automatically approved based on the procedure or diagnosis for which the procedure is requested or an agreement with the performing provider. Precertification review is not required for Emergency services and is not performed where an agreement with the Claims Administrator's local Preferred or Participating Provider does not require such review. The following are general examples of current Precertification review requirements under benefit plans; however, these requirements vary by benefit plan and state and are subject to change.

- Hysterectomy
- Nasal surgery procedures
- Bariatric surgery
- Potentially cosmetic or experimental/investigative procedures

The following information provides more specific information of this benefit plan's Precertification requirements.

1. INPATIENT PRE-ADMISSION REVIEW

Preferred Inpatient Admissions

In accordance with the criteria and procedures described above, Inpatient Admissions, other than an Emergency or maternity admission, must be Precertified in accordance with the standards of the Claims Administrator as to the Medical Appropriateness/Medical Necessity of the admission. The Precertification requirements for Emergency admissions are set forth in the "Emergency Admission Review" subsection of this Managed Care section. A Preferred Hospital, Skilled Nursing Facility, or other Facility Provider in the PPO Network will verify the Precertification at or before the time of admission. However, the Covered Person, not the Hospital, Skilled Nursing Facility or other Facility Provider, is responsible to Precertify an Inpatient Admission under the BlueCard PPO Program. The Claims Administrator will not authorize the Hospital, Skilled Nursing Facility or other Facility Provider admission if Precertification is required and is not obtained in advance. For Covered Person's who reside in the Claims Administrator's local PPO Network service area, the Claims Administrator will hold the Covered Person harmless and the Covered Person will not be financially responsible for admissions to Hospitals, Skilled Nursing Facilities or other Facility Providers in the PPO Network which fail to conform to the pre-admission certification requirements unless: (a) the Provider provides prior written notice that the admission will not be paid by the Claims Administrator; and (b) the Covered Person acknowledges this fact in writing together with a request to be admitted which states that he will assume financial liability for such Facility Provider admission.

Non-Preferred Inpatient Admissions

For a Non-Preferred Inpatient Admission and an Inpatient Admission to a BlueCard PPO Provider, the Covered Person is responsible to have the admission (other than for an Emergency or maternity admission) certified in advance as an approved admission.

a. To obtain Precertification, the Covered Person is responsible to contact or have the admitting Physician or other Facility Provider contact the Claims Administrator prior to admission to the Hospital, Skilled Nursing Facility, or other Facility Provider. The Claims Administrator will notify the Covered Person, admitting Physician and the Facility Provider of the determination. The Covered Person is eligible for Inpatient benefits at the Non-Preferred level shown in the Schedule of Benefits if, and only if, prior approval of such benefits has been certified in accordance with the provisions of this booklet.

b. If such prior approval for a Medically Appropriate/Medically Necessary Inpatient Admission has not been certified as required, there will be a Penalty for non-compliance and the following amount will be deemed not to be Covered Services under this coverage: $1,000 of allowable charges. Such Penalty, and any difference in what is covered by the Claims Administrator and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

   If a Covered Person elects to be admitted to the Facility Provider after review and notification that the reason for admission is not approved for an Inpatient level of care, Inpatient benefits will not be provided and the Covered Person will be financially liable for non-covered Inpatient charges.

c. If Precertification is denied, the Covered Person, the Physician or the Facility Provider may appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Covered Person, Physician, or Facility Provider will be so notified.

2. EMERGENCY ADMISSION REVIEW

a. Preferred Admissions

   It is the responsibility of the Preferred Provider to notify the Claims Administrator of the In-Network Emergency admission.

b. Non-Preferred and BlueCard Provider Admissions

   1. Covered Persons are responsible for notifying the Claims Administrator of a Non-Preferred or BlueCard Provider Emergency admission within two (2) business days of the admission, or as soon as reasonably possible, as determined by the Claims Administrator.

   2. Failure to initiate Emergency admission review will result in a $1,000 reduction in Covered Expense for Non-Preferred services. Such penalty will be the sole responsibility of, and payable by, the Covered Person.

   3. If the Covered Person elects to remain hospitalized after the Claims Administrator and the attending Physician have determined that an Inpatient level of care is not Medically Appropriate/Medically Necessary, the Covered Person will be financially liable for non-covered Inpatient charges from the date of notification.

3. **CONCURRENT AND RETROSPECTIVE REVIEW**

Concurrent review may be performed while services are being performed. This may occur during an Inpatient stay and typically evaluates the expected and current length of stay to determine if continued hospitalization is Medically Appropriate/Medically Necessary. When performed, the review assesses the level of care provided to the Covered Person and coordinates discharge planning. Concurrent review continues until the patient is discharged. Not all Inpatient stays are reviewed concurrently. Concurrent Review is generally not performed where an Inpatient Facility is paid based on a per case or diagnosis-related basis, or where an agreement with the Facility does not require such review.

Retrospective/Post Service Review:

Retrospective review occurs after services have been provided. This may be for a variety of reasons, including the Claims Administrator not being notified of a Covered Person’s admission until after discharge or where medical charts are unavailable at the time of concurrent review. Certain services are only reviewed on a retrospective/post-service basis.

In addition to these standard utilization reviews, the Claims Administrator also may determine coverage of certain procedures and other benefits available to Covered Persons through prenotification as required by the Covered Person’s benefit plan, and discharge planning.

Pre-notification. Pre-notification is advance notification to the Claims Administrator of an Inpatient admission or Outpatient service where no Medical Appropriateness/Medical Necessity review is required, such as maternity admissions/deliveries. Pre-notification is primarily used to identify Covered Persons for Concurrent review needs, to ascertain discharge planning needs proactively, and to identify Covered Persons who may benefit from case management programs.

Discharge Planning. Discharge Planning is performed during an Inpatient admission and is used to identify and coordinate a Covered Person's needs and benefits coverage following the Inpatient stay, such as covered home care, ambulance transport, acute rehabilitation, or Skilled Nursing Facility placement. Discharge Planning involves the Claims Administrator's authorization of covered post-Hospital services and identifying and referring Covered Persons to disease management or case management benefits.

Selective Medical Review. In addition to the foregoing requirements, the Claims Administrator reserves the right, under its utilization and quality management programs, to perform a medical review prior to, during or following the performance of certain Covered Services ("Selective Medical Review") that are otherwise not subject to review as described above. In addition, the Claims Administrator reserves the right to waive medical review for certain Covered Services for certain Providers, if the Claims Administrator determines that those Providers have an established record of meeting the utilization and/or quality management standards for these Covered Services.
Coverage penalties are not applied to Covered Persons where required Selective Medical Review is not obtained by the Provider.

E. OTHER PRECERTIFICATION REQUIREMENTS

Precertification is required by the Claims Administrator in advance for Home Health Care and certain surgical and diagnostic procedures. A complete list of Precertification requirements is shown in the "Services Requiring Precertification" subsection of this Managed Care section. When a Covered Person plans to receive any of these listed procedures, the Claims Administrator will review the Medical Appropriateness/Medical Necessity for the procedure or treatment in accordance with the criteria and procedures described above and grant prior approval of benefits accordingly.

Surgical, diagnostic and other procedures, listed in the "Services Requiring Precertification" subsection of this Managed Care section, that are performed during an Emergency, as determined by the Claims Administrator, do not require Precertification. However, the Claims Administrator should be notified within two (2) business days of Emergency services for such procedures, or as soon as reasonably possible, as determined by the Claims Administrator.

1. Preferred Care

Preferred Providers in the PPO Network must contact the Claims Administrator to initiate Precertification. The Claims Administrator will verify the results of the Precertification with the Covered Person and with the Preferred Provider. If the Preferred Provider is a BlueCard PPO Provider, however, the Covered Person must initiate Precertification.

If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other procedure or treatment listed in the "Services Requiring Precertification" subsection of this Managed Care section, then benefits will be provided for Medically Appropriate/Medically Necessary treatment, subject to a Penalty.

For Preferred Providers in the PPO Network, the Claims Administrator will hold the Covered Person harmless and the Covered Person will not be financially responsible for this financial Penalty for the Preferred Provider's failure to comply with the Precertification requirements or determination, unless a Covered Person elects to receive the treatment after review and written notification that the procedure is not covered as Medically Appropriate/Medically Necessary. In which case benefits will not be provided and the Covered Person will be financially liable for non-covered charges.

2. Non-Preferred Care

For Non-Preferred Care and care provided by BlueCard Providers, the Covered Person is responsible to have the Provider performing the service contact the Claims Administrator to initiate Precertification. The Claims Administrator will verify the results of the Precertification with the Covered Person and the Provider.

If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other procedure or treatment listed in the "Services Requiring Precertification" subsection of this Managed Care section, then benefits will be provided for Medically Appropriate/Medically Necessary treatment, but the Provider's charge less any applicable Coinsurance, Copayments, Deductibles shall be subject to a Penalty of 20% of allowable charges. Such Penalty, and any difference in what is covered by the Claims Administrator and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

F. SERVICES REQUIRING PRECERTIFICATION

The following services must be Precertified whether Preferred (In-Network) or Non-Preferred (Out-of-Network), unless otherwise noted.

1. All Inpatient Admissions

   a. Acute Rehabilitation
   b. Hospice
   c. Maternity (notification only)
   d. Skilled Nursing Facility
   e. Surgical/Non-Surgical (including Transplants)

2. Outpatient Services

   a. Ambulance Services – non-Emergency
   b. Birth Center (notification only)
   c. Day Rehabilitation Program
   d. Dental services as a result of Accidental Injury
   e. Durable Medical Equipment (items over $500 billed amount, including repairs and replacements, and all rentals)
   f. Home Health Care
   g. Outpatient Private Duty Nursing
   h. Prosthetics (items over $500 billed amount, including repairs and replacements)
   i. PET Scan
   j. MRI, MRA

3. Preferred and Non-Preferred Surgical and Diagnostic Services (Inpatient only)

   a. Obesity Surgery
   b. Orthognathic Surgery
   c. Submucous Resection (Nasal Surgery)
   d. Cataract Surgery
   e. Hernia Repair
   f. Operative and Diagnostic Endoscopies
   g. Prostate Surgery
   h. Spinal and Vertebral Surgery

4. Home based infusion therapy

G. OUT-OF-AREA CARE FOR DEPENDENT STUDENTS

If an unmarried Dependent child is a full-time student in an Accredited Educational Institution located outside the area served by your local BlueCard PPO Network, the student may be eligible to receive Non-Preferred care at the Preferred level of benefits. Charges for treatment will be paid at the Preferred level of benefits when the

Dependent student receives care from Providers as described in the subsection entitled "BlueCard PPO Program" of the Your Preferred Provider Organization Plan section of this booklet. However, treatment provided by an educational facility's infirmary for sick/urgent care, for example, may also be paid at the Preferred level of benefits, but the Claims Administrator should be notified within 48 hours of treatment to insure covered services are treated as Preferred Services. Nothing in this provision
will act to continue coverage of a Dependent child past the date when such child's coverage would otherwise be terminated under the Fund's coverage.

RESOLVING PROBLEMS

For purposes of this section only, the term “Member” replaces the term “Covered Person”.

Member Complaint Process

The Claims Administrator has a process for Members to express complaints. To register a complaint, Members should call the Member Services Department at the telephone number on the back of their identification card or write to the Claims Administrator at the following address:

Horizon Healthcare of New Jersey
PO Box 820
Newark, NJ 07101-0820

Most Member concerns are resolved informally at this level. However, if the Claims Administrator is unable to immediately resolve the Member complaint, it will be investigated, and the Member will receive a response in writing within thirty (30) days.

Member Appeal Process

Filing an Appeal. Procedures are available for the resolution of Member appeals. Member appeals may be filed within 180 days of the receipt of a decision from the Claims Administrator stating an adverse benefit determination.

An appeal occurs when the Member or, after obtaining the Member’s authorization, either the Provider or another authorized representative requests a change of a previous decision made by the Claims Administrator by following the procedures described here. (In order to authorize someone else to be your representative for the appeal, you must complete a valid authorization form. Contact the Claims Administrator as directed below to obtain a “Member/Enrollee Authorization to Appeal by Provider or Other Representative” form or for questions regarding the requirements for an authorized representative.)

The Member or other authorized person on behalf of the Member, may request an appeal by calling or writing to the Claims Administrator, as defined in the letter notifying the Member of the decision or as follows:

Appeals Dept, PP-14E
Horizon BCBSNJ
PO Box 420
Newark, NJ 07101-0420

Types of Member Appeals and Applicable Timeframes. Following are the two types of Member appeals and the issues they address:

- **Medical Necessity Appeal Issues** – An appeal by or on behalf of a Member that focuses on issues of Medical Necessity or Medical Appropriateness and requests the Claims Administrator to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on the exclusions for experimental/investigative or cosmetic services.

- **Administrative Appeal Issues** – An appeal by or on behalf of a Member that focuses on unresolved Member disputes or objections regarding a Claims Administrator decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Necessity and Medical Appropriateness, these are not the primary issues that affect the outcome of the appeal.

The timeframes described below for completing a review of each appeal depend on additional classifications:

Standard appeal timeframes apply to both pre-service appeals and post-service appeals that concern claims for non-urgent care.

- Pre-service appeal - An appeal for benefits that, under the terms of the Plan, must be pre-certified or preapproved (either in whole or in part) before medical care is obtained in order for coverage to be available.

- Post-service appeal - An appeal for benefits that is not a Pre-service appeal. (Post-service appeals concerning claims for services that the Member has already obtained do not qualify for review as expedited/urgent appeals.)

Expedited appeal timeframes apply to pre-service requests for urgent care.

- Expedited/Urgent appeal – An appeal that provides faster review, according to the procedures described below, on a pre-service issue. The Claims Administrator will conduct an expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Member's life, health or ability to regain maximum function or would subject the Member to severe pain that cannot be adequately managed while awaiting a standard appeal decision.

Information for the Appeal Review including Matched Specialist's Report. At all appeal levels you may submit additional information pertaining to your case. You may specify the remedy or corrective action being sought. Upon request at any time during the appeal process, you or your authorized representative will be given access to, and copies of, documents, records, and other information relevant to the appeal that is provided to the appeal decision maker(s) for review. Input from a matched specialist is obtained for all Medical Necessity Appeals. A matched specialist is a licensed physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the adverse benefit determination at issue in the appeal and cannot be a subordinate of the person who made that determination.

Appeal Committee Composition and Role. Each Appeals Committee described below designated by the Claims Administrator to review a standard internal first level Administrative Appeal or Medical Necessity Appeal will be comprised of employees of the Claims Administrator who have been designated to act as decision maker(s) on the appeal. The Committee decision maker(s) for any Administrative Appeal or Medical Necessity Appeal will not be those who made the adverse benefit determination at issue in the appeal and will not be subordinates of the person who made that determination. Each Committee will review all relevant information for the appeal, whether from the Member or his authorized representative or obtained from other sources during the investigation of the appeal issues.

Right to Pursue Civil Action. If you are enrolled in a group health plan that is subject to the requirements of Employee Retirement Income Security Act of 1974 (ERISA), you have the right to bring a civil action under Section 502(a) of the Act after completing the Member Appeal processes described here.

Changes in Participant Appeals Processes. Please note that the Member Appeal processes described here may change due to changes in the applicable state and federal laws and regulations and/or accreditation standards, to improve the Participant appeals processes, or to reflect decisions of Group and/or Plan Administrator regarding the administration of member appeal processes for this Plan.

STANDARD APPEALS

There are two levels of appeal. The internal, standard appeal process for Administrative Appeals and Medical Necessity Appeals consists of two (2) internal levels of review—the first by the Claims Administrator and a second by the Plan Administrator. Further review, if any, is only available through the Plan Administrator. There is also an internal Expedited Complaint process available through the Plan Administrator in the event your condition involves an issue that may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed, as determined and validated by your Physician, if reviewed in standard Pre-service appeal timeframes.

Remember, no legal action can usually be taken until all of the Complaint appeal procedures have been followed.

Level One Standard Appeal

An acknowledgement letter and description of the appeal process is mailed within five (5) business days of receipt of a Member appeal. The initial request for an appeal will be evaluated and the decision completed within the following timeframes for a standard appeal on an Administrative Appeal or Medical Necessity Appeal issue:

- Standard Pre-service Appeal – within 15 days of receipt of the appeal request
- Standard Post-service Appeal – within 30 days of receipt of the appeal request

You will be sent written notice of the first level decision within the timeframe stated above that applies to the appeal. If your appeal is denied, the decision notice will state the specific reason for the denial, refer to Plan provision(s) and guidelines on which the decision is made, tell you that relevant information is available, and describe how you can appeal to the next level. The first level appeal decision for a standard appeal is final unless you exercise your right to appeal the decision as described below.

Level Two Standard Appeal

If you are not satisfied with the first level decision, you may file a request for a second level appeal within sixty (60) days. The appeal will be evaluated and the decision completed within the following timeframes for the second level review of a standard appeal on an Administrative or Medical Necessity appeal issue:

- Standard Pre-service Appeal – within 15 days of receipt of the appeal request
- Standard Post-service Appeal – within 30 days of receipt of the appeal request

Under the appeal process in effect for this Plan, the Plan Administrator is responsible for the standard Second Level Administrative Appeal and Medical Necessity Appeal review processes. Once the request for a Second Level Standard Appeal is received, the Claims Administrator forwards the request and all appeal documents in its possession to the Plan Administrator. The Plan Administrator advises you or your authorized representative of the decision regarding your Second Level Standard Administrative Appeal or Medical Necessity Appeal and of any additional appeal rights that may be available for an external appeal.

EXPEDITED APPEALS

If your case involves a serious medical condition which you believe may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed while awaiting a standard appeal decision, you may ask to have your case reviewed in a quicker manner, as an expedited appeal. An expedited appeal consists of only one level of internal review for which the evaluation and decision must be completed within the following timeframe:

- Expedited Pre-service Appeals - within 72 hours of receipt of the appeal request.

To request an expedited appeal by the Plan Administrator, call Member Services at the toll free telephone number listed on the back of your ID card, or call, or fax the Member Appeals Department at 856-382-2416.

Under the appeal process in effect for this Plan, the Plan Administrator is responsible for the Expedited Administrative Appeal and Expedited Medical Necessity Appeal review processes. Once the request for Expedited Appeal is received, the Claims Administrator forwards the request and all appeal documents in its possession to the Plan Administrator. The Plan Administrator advises you or your authorized representative of the decision regarding your Expedited Administrative Appeal or Medical Necessity Appeal and of any additional appeal rights that may be available for an external appeal.