I.U.P.A.T. DISTRICT COUNCIL NO. 51 HEALTH FUND

SUMMARY PLAN DESCRIPTION

May 1, 2019

THE JOINT BOARD OF TRUSTEES

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To All Covered Employees: **May 1, 2019**

This booklet describes the benefits provided to eligible employees and their dependents under the IUPAT District Council No. 51 Health Fund.

The benefits of the Plan generally cover most of your hospital and surgical bills. Your Plan also pays benefits for dental, vision and prescription drug expenses. In addition, death benefits and disability income benefits are provided for employees as specified in this booklet.

Health Benefits and Weekly Disability Income Benefits are payable only in connection with an Injury or Sickness that originates off the job. Death and Accidental Dismemberment Benefits are payable regardless of the origin of the Injury or Sickness.

For simplicity and consistency, the masculine pronoun "he" is used throughout this Summary Plan Description. However, it should be noted that all references to "he" are intended to be applied to both male and female Participants and their eligible dependents. Under no circumstances do any of the below Summary Plan Description specifications apply only to the male gender independently.

Although this booklet is a detailed summary of the Plan provisions, it is not a contract. It does not contain the detailed Agreement and Declaration of Trust or the related Collective Bargaining Agreement. These documents further govern the operation and administration of this plan. The Plan must be interpreted in accordance with these documents, which are available for your inspection at the Fund Office or Local Union Office.

Please bear in mind that the Board of Trustees reserves the right to amend, modify or terminate benefits from time to time and the schedule of benefits contained in this document is therefore subject to amendment by the Board of Trustees. The Board of Trustees also has discretion to interpret the plan of benefits and related documents, and has the authority to make factual determinations in administrating the plan, including the authority to make decisions regarding eligibility for benefits and decisions regarding whether certain medical treatments fall within the terms of the plan. The decisions of the Board of Trustees are final and binding, subject to such legal appeal rights as may exist for participants.

We urge you to read your Plan booklet carefully so that you will be familiar with the benefits that you are entitled and the Plan's eligibility requirements. We hope that you will share our pride in your Plan and the measure of security it provides to those who work in the industry.

Sincerely,

JOINT BOARD OF TRUSTEES

TABLE OF CONTENTS

DEFINITION OF TERMS

Agreement and Declaration of Trust – The Restated Agreement and Declaration of Trust-IUPAT District Council No. 51 Health Fund, restated as of October 31, 1981, and as amended from time to time.

Attending Physician – The Physician who assumes primary responsibility for the care and treatment of a Covered Person.

Birthing Center – A licensed facility set up, equipped and operated under the direction of a Physician solely as a setting for prenatal care, delivery and immediate postpartum care.

Board of Trustees or Trustees – The Joint Board of Trustees of the IUPAT District Council No. 51 Health Fund.

Collective Bargaining Agreement – The contract(s) or labor agreement(s), as amended, between IUPAT District Council No. 51 and subscribing Employers, covering the terms and conditions of contributions to the Trust Fund.

Company or Insurance Company – With regard to life insurance or accidental death and dismemberment benefits, "Insurance Company" means a company contracted by the Fund to provide Life and Accidental Death and Dismemberment benefits.

Contract Administrator – The person or person(s) designated by the Board of Trustees to administer the Plan on a day-to-day basis.

Contributing Employer – An employer who has agreed to make contributions to this Trust Fund in accordance with the terms and conditions of the Collective Bargaining Agreement or other written agreement.

Covered Employment – Work for which a Contributing Employer is required to make contributions to the Trust under the Collective Bargaining Agreement.

Covered Person – Either the Participant, the Retiree or the Participant's or Retiree's Eligible Dependent who is covered by the Plan, unless specifically stated otherwise.

Deductible – The amount of out-of-pocket costs for covered expenses that must be paid by a Covered Person. Expenses in excess of the Usual, Customary and Reasonable level are not included in the deductible amount.

Disability – Your complete inability to perform substantially all of the duties of your occupation because of a medically determinable physical or mental impairment, as certified by a Physician. For Eligible Dependents, Disability means the complete inability to perform substantially all of the normal functions and activities of a person who is the same sex and age and who is in good health.

Effective Date – Originally, May 15, 1955. This booklet describes the benefits as in effect on May 1, 2019.

Eligible Dependent – Any one of the following persons who is not employed by a Contributing Employer and who may be covered for benefits provided by the Trust Fund:

- Your legal spouse, or

- Your child under 26 years of age. "Child" means a natural born child, stepchild, foster child, legally adopted child, a child who is placed with you for adoption (even if the adoption is not yet final) or a child who is under your guardianship.

In addition, the Plan is required to recognize decrees, judgments or orders (including settlements) that the Plan finds to be Qualified Medical Child Support Orders ("QMCSOs") as defined in Section 609 of ERISA. QMCSOs direct a Participant to provide health benefit coverage for dependent children, even if the Participant does not have custody of the children. If you have questions about these special orders or want a copy of the plan's QMCSO procedures, you should contact the Fund Office.

Eligible Participant – Any Employee of a Contributing Employer who has met the eligibility requirements established by the Joint Board of Trustees and who is covered for benefits provided by the Fund under the provisions set forth by the Trustees later in this booklet.

Employee – An individual who is covered by the Collective Bargaining Agreement and who is employed by a Contributing Employer.

Fund Office – The office of the Contract Administrator of the IUPAT District Council No. 51 Health Fund, c/o Zenith American Solutions, 3 Gateway Center, 401 Liberty Ave., Ste. 1200, Pittsburgh, PA 15222-1024, (301) 839-8800 or (800) 424-2707. For claims information call (800) 242-8923.

General Exclusions – Any exclusions that apply to all benefits under the Plan, except Death and Accidental Death and Dismemberment and Vision care as shown in this booklet.

Group Health Plan – A group health plan, other than this Plan, that provides medical coverage on an insured or uninsured basis. This includes any and all insurance, fee for service plans, prepaid coverage plans, employer organization plans, labor-management joint trustee plans, union welfare plans, coverage under a governmental program, and coverage required or provided by law.

Health Benefits – Medical, Prescription Drug, Dental, and Vision Benefits.

Hospital – A lawfully operated institution accredited by the Joint Commission on Accreditation of Health Care Organizations, which maintains and operates organized facilities for major surgery, diagnosis, care and treatment and provides facilities for overnight stay; X-ray and laboratory facilities; the full-time services of licensed graduate registered nurses (R.N.); the

services of legally-qualified physicians and surgeons; and is not, other than incidentally, a place for rest, a place for the aged, or a nursing home. A duly licensed facility for the treatment of substance abuse or a mental or nervous disorder is also considered a Hospital.

Incurred – The date on which a service or supply is furnished.

Injury and Sickness – "Injury" means a wound or damage to the body that is sustained accidentally and by external force, occurs directly and is independent of all other causes. "Sickness" means a disorder or disease resulting in an unsound condition of the mind or body.

Medically Necessary – Services or supplies provided by a Physician or other medical provider that are used to treat an Injury or Sickness according to standard medical practices that are directly related to the care or treatment of the Covered Person and that represent the most appropriate level of care that can be provided safely. Inpatient care in a Hospital is "medically necessary" only if treatment for the Injury or Sickness cannot be provided safely on an outpatient basis. A service or supply is not automatically considered "medically necessary" just because a Physician or other medical provider prescribed it.

Medicare –Any health insurance benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

Outpatient Facility – A lawfully operated clinic or other establishment that maintains and operates facilities for surgery, diagnosis, and treatment on an outpatient basis, and that has an attending medical staff consisting of at least one Physician and anesthesiologist (or a nurse anesthetist working under the supervision of a Physician). An "Outpatient Facility" does not include convalescent homes, nursing homes, homes for the needy, homes providing nursing or custodial care for pre-school children, infirmaries or orphanages, private sanatoriums, maternity homes for pre-natal or post-natal care, mental health facilities or other homes or institutions.

Physician – A person duly licensed and acting within the scope of his or her license to practice medicine or to perform surgery, or a duly licensed practitioner performing services that would be payable under the Plan if performed by a Physician. The Plan will not discriminate in its coverage based on the type of medical provider you use, such as a nurse practitioner rather than a doctor, as long as the provider is licensed to provide the services that you receive and the service is covered by the Plan.

Plan – The plan of benefits and eligibility rules maintained by the IUPAT District Council No. 51 Health Fund, as amended from time to time.

Plan Year – The 12-month period beginning October 1 and ending on September 30.

PPO or Preferred Provider Organization – The provider organization with which the Plan has contracted to reduce health care costs. The PPO enters into contracts with health care providers and facilities to provide services to Plan participants at discounted rates, to reduce costs to both the participants and the Plan. Using a Hospital or Physician that participates in the PPO program results in maximum benefits to the plan participant. The Plan's current PPO is CareFirst BlueCross BlueShield.

PPO Allowance – The negotiated, discounted rate of charges payable by CareFirst BlueCross BlueShield, or any other PPO provider utilized by the Plan.

Retiree – A former Participant who has retired after satisfying the eligibility conditions for Retiree coverage under the Plan.

Schedule of Benefits – The schedule of benefits and deductibles shown in this booklet.

Total Disability – The complete inability to engage in substantial, gainful employment because of a medically determinable physical or mental impairment that is expected to last permanently or indefinitely, as certified by a Physician.

Trust Fund or Fund or Trust – IUPAT District Council No. 51 Health Fund, c/o Zenith American Solutions, 3 Gateway Center, 401 Liberty Ave., Ste. 1200, Pittsburgh, PA 15222-10245, (301) 839-8800 or (800) 424-2707.

Union - IUPAT District Council No. 51.

Usual, Customary and Reasonable (UCR) – The prevailing level of charges by all medical providers within a certain geographic area for the same or comparable care. Standard determination is made by using the Health Insurance Association of America (HIAA) 80th percentile.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

For purposes of determining when you are eligible for coverage under the Plan, each calendar year is divided into four (4) calendar Work Quarters or Employment Quarters, and four (4) Benefit Quarters or Insured Quarters, as follows:

Work/Employment Quarters	Benefit/Insured Quarters
January/February/March	June/July/August
April/May/June	September/October/November
July/August/September	December/January/February
October/November/December	March/April/May

INITIAL ELIGIBILITY

To become eligible initially for benefits, you must have a minimum of 500 hours of service with a Contributing Employer, while working under Covered Employment, reported to the Fund in four (4) or fewer consecutive months. You will become eligible on the first day of the second month following completion of 500 hours of service and will remain eligible up to a maximum of two Benefit Quarters. If you lose your eligibility for four (4) or more consecutive quarters, you will be required to meet the initial Eligibility requirements again.

You will be required to meet the initial Eligibility requirements again if you previously lost your eligibility because your employer failed to remit required contributions to the Fund Office.

If you become disabled as a result of a **work related accident ONLY** prior to meeting the Initial Eligibility requirements you may become eligible by making a personal contribution to cover the hours necessary to meet the Initial Eligibility requirements. This personal contribution will be limited to the maximums currently allowed under the Maintaining Eligibility for Active Participants of 200 hours in any given work quarter, up to a maximum of 350 hours in four consecutive quarters. Upon meeting the Initial Eligibility Requirements by making the allowable personal contribution the current provisions for Emergency Continuation will apply.

CONTINUING ELIGIBILITY

Once you have satisfied the Initial Eligibility Requirements, you can remain eligible for succeeding Benefit Quarters or reinstate coverage after a loss of eligibility of less than four consecutive Benefit Quarters, by meeting *one* of the following requirements:

<u>If you are less than 55 years of age</u>:

- You must have 350 hours reported by a Contributing Employer in the appropriate Calendar Work Quarter in order to be eligible in the corresponding Benefit Quarter;

- You must have 700 hours reported by a Contributing Employer in the appropriate TWO consecutive Calendar Work Quarters in order to be eligible in the corresponding Benefit Quarter; or

- You must have 1,400 hours reported by a Contributing Employer in the appropriate FOUR consecutive Calendar Work Quarters in order to be eligible in the corresponding Benefit Quarter.

If you are age 55 or older:

- You must have 300 hours reported by a Contributing Employer in the appropriate Calendar Work Quarter in order to be eligible in the corresponding Benefit Quarter; or

- You must have 600 hours reported by a Contributing Employer in the appropriate TWO consecutive Calendar Work Quarters in order to be eligible in the corresponding Benefit Quarter; or

- You must have 1000 hours reported by a Contributing Employer in the appropriate FOUR consecutive Calendar Work Quarters in order to be eligible in the corresponding Benefit Quarter.

CONTINUATION OF ELIGIBILITY BY PERSONAL CONTRIBUTIONS

Retirees. A person who retires because of disability or is receiving a pension under the International Union of Painters and Allied Trades Industry Pension Fund will be eligible for all health benefits, excluding weekly disability, provided contributions are made by him or on his behalf. The specific eligibility requirements are contained in the "Retiree Eligibility" section later in this booklet.

Maintaining Eligibility for Active Participants. An Active Participant may be permitted to maintain coverage by making a personal contribution to "buy" the hours necessary to meet the eligibility requirements. You may "buy" a maximum of 200 hours in any given work quarter, up to a maximum of 350 hours in four consecutive quarters. A personal contribution may be made to cover a shortfall in any of the four preceding calendar work quarters in order to meet the continuing eligibility test of the one, two, or four quarter look backs. In addition, you must be eligible in the previous benefit quarter in which you plan to make personal contributions and you must be available to work. Disability Income and/or Loss of Time Benefits are not provided to a participant whose eligibility has been continued based on a personal contribution. Your Personal Contribution must be received in the Fund Office within 20 days following the date of your Work History advising of the payment schedule.

COBRA Continuation Coverage. A participant or dependent, who meets the requirements for a continuation of coverage under the federal statute known as "COBRA", may continue eligibility for limited periods of time, provided such individual elects coverage and pays the COBRA premium established from time to time by the Trustees. The plan rules regarding COBRA are more fully described in the section entitled "*Continuation of Coverage Under COBRA*".

EMERGENCY CONTINUATIONS

If you are otherwise eligible for benefits but not working due to Sickness or Injury, and written proof has been submitted to the Fund Office, you will be credited with 40 hours for each week that you receive Weekly Disability Income from the Fund or Workers' Compensation, up to a maximum of 26 weeks of continuous disability due to a non-work related condition or 52 weeks due to a work related injury. You will be treated as eligible for benefits as long as the hours credited because of your disability are sufficient to maintain eligibility under the Plan. If you are receiving Workers' Compensation Benefits, you must submit written proof of your entitlement to those benefits in order to be credited with hours under this section.

The Plan will credit up to forty (40) hours a week, for up to fifty-two (52) weeks, for eligible participants and their eligible dependents in the event they lose their eligibility due to a Worker's Compensation disability.

If you lose your eligibility due to a Workers' Compensation disability, you and your eligible dependents will be covered for all allowable benefits except Weekly Disability Income Benefits.

In order to determine the Weekly Disability Income benefits payable to you, a continuous period of Disability includes all periods of Disability resulting from the same or related cause or causes that are separated by less than two weeks of continuous, full-time, active work. Periods of Disability resulting from different or unrelated causes are considered separate periods of Disability, regardless of whether you return to work between each period of Disability.

DEPENDENT ELIGIBILITY

Your eligible dependents are eligible for benefits as long as you, the eligible employee participant, retain your eligibility. Dependent coverage may be continued under certain circumstances described in this section, or under COBRA, described later.

Your legal spouse is eligible for full dependent coverage.

Your child is eligible for dependent benefits from birth until his/her 26th birthday.

Your child to whom you are required to provide health coverage pursuant to a QMCSO is also eligible for coverage.

If you add or lose an eligible dependent, please notify the Fund Office immediately.

RETIREE ELIGIBILITY

You are eligible for coverage as a retiree if you are retired from active employment of any kind within the classification covered by a collective bargaining agreement with IUPAT District Council No. 51 and you meet all of the following requirements:

1. You are receiving a pension benefit from the International Union of Painters and Allied Trades Industry Pension Fund; and

2. You have either:

    a) Attained age 55, or

    b) Are under the age of 55, but are receiving a full, unreduced monthly pension benefit from the International Union of Painters and Allied Trades Industry Pension Fund, based on 60,000 hours or more of covered employment; and

3. You either:

    a) Have been eligible for benefits from this Plan for at least 16 out of the 20 Benefit Quarters (4 out of 5 years) immediately preceding your date of retirement; or

    b) Had eligibility under this Plan that was followed by continuous eligibility under another Plan sponsored by an employer that is signatory to an agreement with the IUPAT DC 51 AND your total combined eligibility equals or exceeds eligibility for at least 16 out of 20 Benefit Quarters (4 out of 5 years) immediately preceding your date of retirement; and

4. You make the required personal contribution to the Fund, beginning the first month that you become eligible in accordance with the above provisions. Once you become eligible for Retiree benefits under these provisions, you must remain continuously eligible by making your required personal contribution each month. If you fail to make your required contribution and your retiree benefit is terminated, you cannot thereafter become eligible to receive a Retiree benefit under the plan.

If you are Disabled, you may participate in the Plan as a Retiree, if you meet *all* of the following requirements:

- You were eligible for benefits from this Plan at the time of your retirement;
- You have filed for a Social Security Disability Award;
- The Trustees approve your application; and
- You make the required personal contributions to the Fund.

The monthly cost for benefits is determined by the Board of Trustees on a regular basis and may be changed by the Board of Trustees from time to time. The Board of Trustees may require the retiree payments to be made on a quarterly basis.

For retirees who retired on or after January 1, 1999, the required monthly contribution is $800.00 for those whose current age is 65 years or younger, and $300.00 for those whose current age is 65 years or older. For retirees who retired prior to January 1, 1999, the required monthly contribution is; 65-74 years of age- $50.00; and 75 years of age and older- $0.

As long as payments are made to maintain your eligibility, your qualified dependents will also be eligible for benefits during your lifetime. In the event of your death, your spouse's and dependent children's coverage will continue for the remainder of your spouse's lifetime or until the date s/he remarries or the date that your dependent(s) no longer qualify for coverage in accordance with the Dependent Eligibility requirements of the Fund, whichever is earlier, provided your spouse continues to make the required personal contributions.

Because the Health Fund is a separate entity from the IUPAT Pension Fund, you must contact the Fund Office regarding retiree coverage when you apply for your pension benefits. Failure to advise the Fund Office of your impending retirement may result in a permanent loss of coverage for you and your dependents.

PERSONAL CONTRIBUTIONS FOR RETIREES WHO RETURN TO WORK

Retirees who return to work after retirement, during a period for which a waiver of suspension of benefits is in place with the International Union of Painters and Allied Trades Industry Pension Fund, and who work insufficient hours to meet the requirements for Continuing Eligibility will be allowed to off-set their required retiree personal contribution amount by the amount of the employer contributions that are received on their behalf during the corresponding work quarter.

Coverage under COBRA will continue to be made available to those persons who qualify.

THE RETIREE BENEFITS PROVIDED UNDER THIS PLAN ARE NOT VESTED BENEFITS. THE BOARD OF TRUSTEES RESERVES THE RIGHT IN ITS SOLE DISCRETION TO DETERMINE ELIGIBILITY FOR BENEFITS, TO INTERPRET THE TERMS OF THE PLAN, TO AMEND, MODIFY OR TERMINATE HEALTH CARE COVERAGE OR REQUIRE ADDITIONAL CONTRIBUTIONS. CONTACT THE TRUST FUND FOR FURTHER INFORMATION ABOUT RETIREE BENEFITS AT THE TIME YOU ARE PLANNING TO RETIRE.

TERMINATION OF COVERAGE

Your coverage under the Plan will terminate on the earliest of the following dates:

- The date you fail to meet the eligibility requirements of the Plan,

- The date your employer is considered to be in violation of the collective bargaining agreement for failure to remit all required contributions, or

- The date the Plan is terminated.

Coverage for your eligible dependents will automatically terminate on the earliest of the following dates:

- The date your benefits terminate,
- The date your child no longer meets the definition of an eligible dependent as previously described in this booklet,
- In the case of a spouse, the date your divorce or legal separation decree becomes final, or
- The date coverage for dependents is terminated by the Trustees.

If you or your eligible dependents are hospitalized on the date that your benefit would otherwise end, all benefit coverage to which you are entitled will be automatically extended throughout the period of hospital confinement or, if earlier, 30 days from the date the benefit would have otherwise ended.

When coverage under this Plan is terminated, you or your dependent, when applicable, will receive a certificate showing the period of coverage under this Plan. If you or your dependents become covered under another group health plan that has exclusions for pre-existing conditions, this proof of coverage may help reduce the waiting period for coverage for that condition under this new plan. A certificate of coverage may be requested from this Plan at any time within 24-months following termination of coverage. Contact the Fund Administrator to request a certificate or if you have questions regarding this information.

The Fund will send a Certificate of Creditable Coverage to you and your Dependents that shows how much coverage you have had under the Plan, within a reasonable time after you lose coverage under the Plan for any reason, or you would lose coverage under the Plan if you had not elected COBRA coverage. You do not need to make a request to get a Certificate in these situations as the Certificate will be automatically sent to you; however you or your Dependents may request a Certificate of Creditable Coverage for up to two years (24 months) after you lose coverage under the Fund by contacting the Eligibility Department at (301) 839-8800 or toll free at 1-800-424-2707.

The Certificate will be sent to you by first class mail at your (or your Dependents, where applicable), last known address, unless you (or your Dependents, where applicable) provide another address at the time of the request. The Fund will also send a Certificate, upon your (or your Dependents, where applicable) request to another plan in which you enroll. The Certificate will also be sent directly to another plan in which you enroll upon the request of the plan, providing you have authorized the Fund to send the Certificate. In all cases, absent extenuating circumstances, the Fund will be able to mail your Certificate within ten days following the receipt of your request.

CONTINUATION OF COVERAGE UNDER COBRA

Federal law, commonly referred to as "COBRA", was enacted (Public Law 99-272, Title X) requiring that sponsors of group health plans offer Participants and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. You and your covered family members may be offered COBRA continuation coverage when your coverage under the plan would otherwise end because of a life event known as a "qualifying event." COBRA continuation coverage generally consists of the coverage under the plan that you and your family members had immediately before the qualifying event.

Each employee and family member who elects COBRA continuation coverage will have the same rights under the Plan as other similarly situated participants or beneficiaries covered by the Plan who did not have a qualifying event. If the Plan changes benefits, premiums, etc., continuation coverage changes accordingly.

COBRA does not affect certain continuation coverage provisions already included in the Plan. The Plan currently provides for continued coverage for participants who choose to make personal contributions during periods of disability or when coverage is lost due to lack of work.

WHEN COBRA CONTINUATION COVERAGE IS AVAILABLE

The specific qualifying events that trigger the right to elect COBRA continuation coverage are listed below. After a qualifying event, COBRA continuation coverage will be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

If you are an ***employee***, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the ***spouse*** of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occurs:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

An employee's ***dependent child*** will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events occurs:

- The employee dies;
- The employee's hours of employment are reduced;
- The employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Qualified beneficiaries will be offered COBRA continuation coverage only after the Health Fund has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, your employer must notify the Health Fund of the qualifying event. You are responsible for notifying the Fund, if and when you become eligible for Medicare (Part A, Part B or both).

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse, eligibility for Medicare or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Fund in writing within 60 days after the qualifying event occurs. This notice should be sent to the Fund at the address specified in the section, *How to Contact the Fund,* below. A notice mailed to the Fund will be considered provided on the date of mailing.

The notice must include the employee's name, the name of the spouse and/or dependent child, the nature of the qualifying event (e.g. divorce, legal separation, entitlement to Medicare or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or legal separation, date Medicare became effective or the date the dependent child reached the Plan's limiting age, married or lost full-time student status).
If notice is not provided during this 60-day notice period, the spouse or dependent child who loses coverage will be not offered the opportunity to elect COBRA continuation coverage.

DURATION OF COBRA COVERAGE

COBRA continuation coverage is a temporary continuation of coverage. The duration of the coverage depends on the nature of the qualifying event that causes the loss of coverage:

- When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or a dependent

child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

- When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally only lasts for up to a total of 18 months.

EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

There are three ways in which the 18-month period of COBRA continuation coverage can be extended.

Disability extension. If the Social Security Administration (SSA) determines that you or a family member covered under the Plan is disabled and the Fund receives timely notice of that determination, you and your other family members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months of COBRA coverage. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18-month period of COBRA continuation coverage. In order for the extension to be available, you must notify the Fund in writing of the disability determination during the first 18 months of COBRA continuation coverage and no more than 60 days after the latest of: (i) the date of the SSA determination, (ii) the date of the qualifying event or (iii) the date coverage would end on account of the qualifying event.

The notice must be sent to the Fund at the address specified in the section, *How to Contact the Fund*. It must include the employee's name, the name of the disabled individual, as well as a copy of the Social Security Administration disability determination.

A notice mailed to the Fund will be considered provided on the date of mailing.

If notice is not provided within the above timeframes, the 18-month maximum coverage period will not be extended.

The disability extension is available only for as long as the family member remains disabled. The Fund must be notified within 90 days of the Social Security Administration final determination that the individual is no longer disabled. Continuation coverage will end on the first day of the month that begins more than 30 days after the date of the determination.

Second qualifying event. If your family experiences a second qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months of COBRA coverage. This extension may be available if the employee or former employee dies, is divorced or legally separated, or if a child no longer qualifies as a dependent child under the terms of the Plan, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Coverage will be extended only if you or your family members provide notice of the second qualifying event to the Fund no more than 60 days after the event occurs.

This notice should be sent to the Fund at the address specified in the section *How to Contact the Fund.* The notice must include the employee's name, the name of the spouse and/or dependent child, the nature of the second qualifying event (e.g. divorce, legal separation or a child's loss of

dependent status) and the date the qualifying event occurred (date of divorce or legal separation or the date the dependent child reached the Plan's limiting age, married or lost full-time student status).

A notice mailed to the Fund will be considered provided on the date of mailing.

If notice is not provided during this 60-day notice period, COBRA continuation coverage will not be extended beyond the initial 18-month period.

Employee's entitlement to Medicare. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before employment terminates, COBRA continuation coverage for the spouse and children can last up to 36 months after the date of Medicare entitlement, which would be 28 months after the date of the qualifying event (36 months minus 8 months).

ELECTING COBRA CONTINUATION COVERAGE

Once the Fund receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. You and/or your spouse and dependent children will have 60 days in which to elect COBRA continuation coverage. This 60-day election period begins on the later of:

- The date coverage would end because of the qualifying event, or,
- The date the Fund provides notice of the right to elect COBRA.

A COBRA election mailed to the Fund will be considered made on the date of mailing.

If COBRA continuation coverage is not elected during the 60-day election period, the right to elect continuation coverage will be lost.

You and/or your spouse and dependent children may elect COBRA continuation coverage for all qualifying family members. However, each qualified beneficiary has an independent right to elect continuation coverage. Thus, both you and your spouse may elect continuation coverage, or only one of you may do so. You may also elect to continue coverage on behalf of your dependent children only.

PAYING FOR COBRA CONTINUATION COVERAGE

You must pay the cost of COBRA continuation coverage. The cost of coverage is determined by the Board of Trustees. The Trustees will change this cost periodically since it is based on the actual cost of providing these benefits to you.

Your first payment must be made within 45 days of the date that the COBRA election was made. If payment is not received within this 45-day period, the Fund will terminate coverage retroactively to the beginning of the maximum coverage period.

After the initial premium payment is made, all other premiums are due on the first day of the month to which such premium will apply, subject to a 30-day grace period. ***A premium payment that is mailed will be considered made on the date of mailing.*** If the full amount of the premium is not paid by the due date or within the 30-day grace period, COBRA continuation coverage will be canceled retroactively to the first day of the month with no possibility of reinstatement.

Generally, the amount of the premium for COBRA continuation coverage will not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. In the case of an extension of COBRA continuation coverage due to a disability, the amount of the premium will not exceed 150 percent of the cost of coverage.

WHEN COBRA CONTINUATION COVERAGE ENDS

A qualified beneficiary's COBRA continuation coverage will end before the expiration of the maximum coverage period if any of the following events occurs:

- The premium for coverage is not paid for in a timely manner;
- After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the individual may have;
- After electing COBRA, the qualified beneficiary enrolls for Medicare;
- If coverage is extended on account of disability, the Social Security Administration makes a determination that the individual is no longer disabled; or
- The Fund terminates and no longer provides group health coverage to covered employees, retirees, spouses, and dependents.

IF YOU HAVE QUESTIONS

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Fund as indicated below. For more information about your rights under ERISA including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.).

KEEP THE FUND INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Fund informed of any changes in the addresses of family members. If you have a qualifying event, you should also keep a copy of any notices you send to the Fund for your records.

HOW TO CONTACT THE FUND

All required notices should be mailed to the Fund at the following address:

Zenith American Solutions
IUPAT District Council No. 51 Health Fund
3 Gateway Center
401 Liberty Ave., Ste. 1200
Pittsburgh, PA 15222-1024

You can also call the Fund at (301) 839-8800 or 800-424-2707 if you have any other questions about COBRA continuation coverage.

COVERAGE WHILE ON FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth, adoption, or placement with you for adoption of a child;
- The serious illness of your spouse, child, or parent; or
- Your own serious illness.

The FMLA permits you to take up to 26 weeks of unpaid leave during any 12 month period due to:

- A serious illness or injury sustained in the line of duty by your spouse, parent, child or one to whom you are next of kin if the individual is a current member of the Armed Forces, the National Guard or Reserves or is a member of the Armed Forces, the National Guard or Reserves on the temporary disability retired list ("covered military member").

The FMLA also permits leave if the covered military member is a member of the reserve components (e.g., Army National Guard of the U.S., Army Reserve, Marine Corp Reserve, etc.) or a retired member of the Regular Armed Forces or Reserve, and their active duty or call to active duty is coupled with one of the following qualifying exigencies:

- S*hort notice deployment*:

When the covered military member is notified of his or her deployment in support of a contingency operation seven or less calendar days prior to the deployment, you are entitled to up to seven calendar days leave beginning the day the covered military member receives notice of the impending deployment.

- *Military events and related activities*:

You are entitled to take leave to attend any official ceremony, program or even the military sponsors related to the covered military member's active duty or call to active duty status and to attend family support or assistance programs and informational briefings sponsored or promoted by the military,

military service organizations or the Red Cross related to the covered military member's active duty or call to active duty status.

- *Childcare and school activities*:

You are entitled to take leave to:

(i) arrange for alternative childcare when the active duty or call to active duty status of a covered military member necessitates a change in the existing childcare arrangement for a biological, adopted, or foster child, a stepchild, or a legal ward of a covered military member, or a child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence;

(ii) provide childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the need to provide such care arises from the active duty or call to active duty status of a covered military member for a biological, adopted, or foster child, a stepchild, or a legal ward of a covered military member, or a child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence;

(iii) enroll in or transfer to a new school or day care facility a biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence, when enrollment or transfer is necessitated by the active duty or call to active duty status of a covered military member; and

(iv) attend meetings with staff at a school or a daycare facility, such as meetings with school officials regarding disciplinary measures, parent-teacher conferences, or meetings with school counselors, for a biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence, when such meetings are necessary due to circumstances arising from the active duty or call to active duty status of a covered military member.

- *Financial and legal arrangements*:

You are entitled to take leave to:

(i) make or update financial or legal arrangements to address the covered military member's absence while on active duty or call to active duty status, such as preparing and executing financial and healthcare powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, or preparing or updating a will or living trust; and

(ii) act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging, or appealing military service benefits while the covered

military member is on active duty or call to active duty status, and for a period of 90 days following the termination of the covered military member's active duty status

- *Counseling*:

You are entitled to take leave to attend counseling provided by someone other than a health care provider for oneself, for the covered military member, or for the biological, adopted, or foster child, a stepchild, or a legal ward of the covered military member, or a child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence, provided that the need for counseling arises from the active duty or call to active duty status of a covered military member.

- *Rest and recuperation*:

You are entitled to take up to five days leave for each instance in which the covered military member is on short-term, temporary rest and recuperation leave during the period of deployment.

- *Post-deployment activities*:

You are entitled to take leave to attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member's active duty status.

You are also entitled to take leave to address issues that arise from the death of a covered military member while on active duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements.

- *Additional Activities*:

You are entitled to take leave to address other events which arise out of the covered military member's active duty or call to active duty status provided that you and the employer agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave. You are not entitled to take leave because of a qualifying exigency if the covered military member is on active duty or call to active duty status in support of a contingency operation *as a member of the Regular Armed Force.*

During your leave, you can continue all of your medical coverage and other benefits offered through the Fund. You are generally eligible for a leave under the FMLA if you:

- Have worked for a covered employer for at least 12 months (months need not be consecutive);

- Have worked at least 1,250 hours during the 12 months immediately preceding the date your leave is to begin; and

- Work at a location where at least 50 employees are employed by the employer within 75 miles of such location.

The Fund will maintain the employee’s eligibility status until the end of the leave, provided the

Contributing Employer properly grants the leave under the FMLA and the Contributing Employer makes the required notification and payments to the Fund. Call your employer to determine whether you are eligible for FMLA Leave.

COVERAGE WHILE ON MILITARY LEAVE

If you go into active military service for up to 31 days, coverage for you and your dependents will remain in effect as if you had remained actively employed.

If you go into active military service for more than 30 days, your coverage will terminate upon the 31st day and the coverage for your eligible dependents will terminate once the Fund Office determines that they no longer meet the eligibility requirements listed under the section titled "Continuing Eligibility". You and your dependents may be able to continue coverage at your own expense for up to 24 months from the date you went on military leave provided you make any required contributions.

Any period of leave of absence under the provisions of the Uniformed Services Employment and Reemployment Rights Act ("USERRA") will not be counted as a break in coverage. In order to have coverage reinstated by the Plan after military service, you must apply for reinstatement in accordance with USERRA. If your period of service in the uniformed services was less than 31 days, you must report to your Employer for reemployment by the first day of the first regularly scheduled work period and the expiration of eight hours after a period allowing your safe transportation from the place of service to your residence.

If your period of service in the uniformed services was between 31 days and 180 days, you must submit an application for reemployment not later than 14 days after the completion of your period of service. If your period of service was for more than 180 days you must submit your application for reemployment with your employer not later than 90 days after the completion of your period of service. If you have been hospitalized, or are convalescing from an illness or injury incurred or aggravated during your tour of duty in the uniformed services, you have until your recovery from that illness or injury, not to exceed two years, to submit an application for reemployment.

SUMMARY OF BENEFITS FOR ELIGIBLE PARTICIPANTS AND DEPENDENTS

Benefit levels are maintained at the highest level the Trustees feel is practical. However, benefits must be reviewed from time to time, as economic circumstances indicate, and adjusted upward or downward as required. The Fund Office will notify you of any changes to the benefits, and these changes in benefit levels will affect claims incurred on or after the effective date of the change.

This summary is intended merely to provide general information concerning the benefit program. The payments for specific claims are subject to the rules, regulations and limitations as have been or may be adopted under authority of the Joint Board of Trustees. Please note that the following Annual Deductibles and Annual Out-of-Pocket Maximums are based on expenses incurred in a calendar year.

SCHEDULE OF BENEFITS

Annual Deductible:

Individual $500
Family $1000

Note: An individual family member who meets the individual deductible of $500 will be treated as satisfying the deductible, regardless of whether the family deductible is met.

Amount Payable after Deductible:

If you use a PPO Doctor or Facility**:**
Plan pays ..... 80% of PPO Allowance
Your Cost ..... 20% of PPO Allowance

If you do NOT use a PPO Doctor or Facility:
Plan pays .....50% of UCR
Your cost .....50% of UCR

Annual Out-of-Pocket Maximum .....$4,000 for an individual
.....$8,000 for a family

These maximums include the amounts you pay in deductibles and coinsurance, but only for In Network PPO care on essential benefits (or for emergency services obtained from a non-PPO provider or facility). Once this maximum has been met, the Fund will pay 100% of the PPO allowance for the remainder of the calendar year. The Annual Out-of-Pocket Maximum **does not** apply to claims for services rendered by Doctors or Facilities outside of the PPO network except for Emergency Expenses.

Also, if a family member reaches the individual out of pocket maximum in a year, the maximum will have been met for that individual, regardless of whether the family out of pocket maximum has been met in that year.

Hospital

Daily Room & Board Rate:
In-Network..... 80% of PPO Allowance
Out-of-Network.....50% of UCR for Semi-private room

Intensive Care Units (including Neonatal):
In-Network..... 80% of PPO Allowance
Out-of-Network.....Two times the Semi-private room payable at 50%

Hospital Ancillary (miscellaneous) Expenses:
In-Network..... 80% of PPO Allowance
Out-of-Network.....50% of UCR

Emergency Services:

In-Network……..80% of PPO Allowance.

Out-of-Network…… 80% of UCR Allowance

Surgical Expense Benefit:

In-Network..... 80 % of PPO Allowance
Out-of-Network.....50% of UCR

Doctor Calls (Inpatient, Office and Home)**:**

In-Network..... 80% of PPO Allowance
Out-of-Network.....50% of UCR

Diagnostic X-ray & Laboratory Expense Benefit:

In-Network..... 80% of PPO Allowance
Out-of-Network.....50% of UCR

Preventive Care Benefits:

Children up to age 19 ..... 100% when provided In-Network
Adult Annual Wellness .....100% when provided In-Network
When preventive services are provided out of the PPO network, the Plan pays 50% of the UCR.

Hospice Care:

Inpatient Treatment
In-Network ..... 80% of PPO Allowance
Out-of-Network.....50% of UCR

Outpatient Treatment
In-Network..... 80% of PPO Allowance
Out-of-Network.....50% of UCR

Psychiatric Care:

Inpatient:
In-Network..... 80% of PPO Allowance
Out-of-Network.....50% of UCR

Outpatient Psychiatric Treatment (Physician Charges):

In-Network..... 80% of PPO Allowance
Out-of-Network.....50% of UCR

PREFERRED PROVIDER NETWORK

The Board of Trustees has adopted a preferred provider network, which they urge you to utilize to minimize costs to you and to the Plan.

The Preferred Provider Organization used by the Plan is:

Local Area ("NetLease" Access):	CareFirst BlueCross BlueShield: P.O. Box 981633 El Paso, TX 79998-1633 Phone: (800) 235-5160
Local Area ("NetLease" Access):	Group ID: W32W Benefit Plan: /580 Prefix: A81
Outside Local Area ("FlexLink Access):	Group ID: 1901753-0001 Benefit Plan: 190/690

In an effort to improve the quality of your health benefits while reducing health care costs, the Plan has contracted with CareFirst, a preferred provider organization (PPO). A preferred provider organization is a company that has entered into contracts with health care providers who have agreed to provide their services to individuals covered by the Plan under terms that reduce costs for both you and the Plan. If you or your Eligible Dependents receive care or services from a Hospital or Physician that participates in the PPO program, the maximum benefit amount you can receive is increased.

Members who live in the local area (inside Maryland, DC or Northern Virginia) may locate CareFirst providers by calling CareFirst directly at the number shown on your medical identification card or by visiting the PPO network's website at www.carefirst.com. Your CareFirst "NetLease" group number is W32W; Benefit Plan is 190/690. Local members as well as their providers should call Zenith American Solutions at 301-839-8800 or 1-800-242-8923 to confirm eligibility, benefits and claim status.

Members who live outside of the local area should call CareFirst to verify participating providers. Your CareFirst "FlexLink" group number is 1901753-0001; Benefit Plan is 190/690. Providers should call the local Blue Cross Blue Shield company to verify claims status. FlexLink members as well as their providers should call Zenith American Solutions at 301-839-8800 or 1-800-424-2707 to confirm eligibility, benefits and claim status.

PLEASE NOTE: The discounted PPO rates are only available from PPO providers and/or facilities. Individuals who choose not to use PPO providers will be subject to a 50% co-insurance benefit for all Usual, Customary and Reasonable charges...

If you or your Eligible Dependents receive care or services from a Hospital or Physician that participates in the PPO program, be sure to tell the Hospital or Physician that you are a member of the CareFirst PPO program. The participating provider will file the claim directly.

It is often necessary for a physician to refer certain types of services to other specialized medical service providers, such as anesthesiologists, pathologists for blood work, and radiologists for x-ray and MRI. Provided the referral is from a network provider and you have reason to believe the provider of one of these Ancillary Services is in-network, the plan will pay at the higher "in-network" rate. It is your right and your responsibility to direct that these additional medical services are provided by physicians and facilities that also participate in the CareFirst PPO to ensure that the cost of these services can be reimbursed by the Plan at the negotiated preferred rate.

UTILIZATION REVIEW

The PPO program includes several procedures that are intended to ensure that you and your Eligible Dependents receive the best care at the most reasonable price. These procedures include Pre-Admission Certification, Concurrent Review and Case Management, as described below.

PRE-ADMISSION CERTIFICATION AND CONCURRENT REVIEW

Pre-admission certification is a procedure used to evaluate a planned inpatient stay before admission or, in the case of an emergency, right after the admission. In some cases, it may be possible to safely treat you in a less costly setting – an ambulatory surgery center, hospital outpatient department or in a doctor's office.

If a hospital admission is necessary, the utilization review specialist works with your Physician to determine the number of days needed to provide treatment.

During hospitalization your progress is continuously monitored. Any additional days requested are reviewed to ensure the additional days are medically necessary (Concurrent review).

How the Program Works

You, your Eligible Dependents or your Attending Physician must call American Health Holdings, the utilization review specialist before the planned admission, or as soon as possible after an emergency admission. The number is (800) 641-5566. The utilization review specialist will ask the caller to provide the patient's name, age, and doctor's name and phone number. The reviewer then calls the Attending Physician to determine medical necessity and appropriateness, assigns an initial length of stay and monitors your case until discharge.

If the clinical information provided meets the appropriate medical criteria, a notice of your certified admission will be sent to you, your Attending Physician and the Fund Office within 24 hours after certification.

CASE MANAGEMENT

The Case Management Program identifies patients admitted with potential long-term, high-cost sicknesses. Although participation in the Case Management Program is voluntary, if you do not agree to participate upon the request of the Fund, your claims will be treated as out of network claims, and will be paid at 50% of the UCR.

How the Program Works

When a potential long-term hospitalization is identified through either the pre-certification or concurrent review process, a case manager is notified. The case is then evaluated to determine the appropriate level of care, health benefits availability and proposed costs for available services.

The case manager needs your written permission to meet with your Attending Physician in order to discuss planning recommendations concerning alternative services. When a treatment plan is selected, the case manager continues to work to implement the plan and to monitor the case until management is no longer beneficial.

The Plan will pay the full cost of second options or pre-operation testing ordered by Utilization Review.

ADDITIONAL INFORMATION

Further information on the medical review programs is available from the Fund Office.

NON-PREFERRED PROVIDERS

You and your eligible dependents may obtain medical care from the physician and facility of your choice. However, please be aware that services obtained from a physician or facility that does not participate in the CareFirst PPO network will be paid at a reduced benefit. This means that you and your family will have higher out-of-pocket expenses.

In addition to the reduced benefits, the out-of-pocket expenses that you are responsible for are NOT counted towards the out-of-pocket maximum.

Co-Insurance for Emergency Services

There is a limited exception to this rule. When services are rendered on an Emergency (life-threatening injury or illness) basis at a Non-Network Hospital or you are admitted to a Network Hospital but one of the treating providers is not a PPO provider, benefits will be paid at 80% of the Usual and Customary (UCR) Allowance. This means the Fund will pay the same co-insurance percentage that it would have paid if the provider or facility were a member of the Networks. However, because no PPO discount was given for using out of network providers and facilities, your out-of-pocket expenses will likely be higher than those incurred for using an in-network provider, even with the increased amount paid by the Fund.

Out of Pocket Maximum for Out of Network Emergency Services

Also, when you receive emergency services (life threatening injury or illness) at a Non-Network hospital or from a Non-Network Physician, your out of pocket expenses will be counted towards your Out of Pocket Maximum. After the out of pocket maximum is satisfied, your emergency services benefit will increase to 100% of any PPO allowance or 100% of the UCR allowance for all approved emergency services in the calendar year.

MAJOR MEDICAL EXPENSE BENEFITS

Major Medical Expense benefits provide payment of a percentage of covered charges incurred in connection with a Sickness or an Injury up to the maximum amount shown in the Schedule of Benefits. Major Medical Expense benefits are payable only after you have satisfied the annual deductible as shown in the Schedule of Benefits.

The deductible applies to you and each of your Eligible Dependents only once during a calendar year, regardless of the number of Injuries or Sicknesses you have. Once two individuals in your family meet the annual deductible, the deductible is satisfied for that calendar year for all your family members. However, where an individual family member meets the individual deductible amount, the deductible will be met for that individual, even if the family deductible is not met in that year for other family members.

OUT-OF-POCKET MAXIMUM

The Plan pays a percentage of the covered medical charges in excess of the annual deductible until the annual out-of-pocket maximum has been met. The current annual out-of-pocket maximums are $4,000 for an individual and $8,000 for a family. You are responsible for amounts in excess of the percentage paid by the Fund until the maximum has been met. Once you have met the maximum, the Fund will pay for all covered charges made by network participating facilities and Physicians at 100% for the remainder of the calendar year.

Only expenses incurred at CareFirst Network facilities and providers will be counted towards the out-of-pocket maximum (except for emergency services). Non-Network expenses do not count towards the out-of-pocket maximum.

The Trustees reserve the right to review the out-of-pocket maximum and adjust the figure upward or downward as economic circumstances dictate. The Fund Office will notify you of any changes to the benefits, and these changes in benefit levels will affect claims incurred on or after the effective date of the change.

Note: there are separate Out of Pocket Maximums for Prescription Drug expenses. See below.

BENEFIT PERIOD

A benefit period is established and benefit payments begin after you or your dependents incur eligible charges, which exceed the applicable deductible amount for the calendar year. All eligible charges incurred during a benefit period are used in computing benefit payments.
A benefit period terminates on the earliest of: (a) the last day of the calendar year in which it was established, or (b) the day you and/or your dependents cease to be eligible for Major Medical Expense benefits.

COVERED MEDICAL EXPENSES

"Covered Medical Expenses" are the reasonable and necessary expenses actually charged to a Covered Person for treatment, services and supplies as recommended by the attending Physician, provided those charges are the Usual, Customary and Reasonable charges for such treatment, services and supplies.

Covered Medical Expenses include:

- Daily Hospital Room and Board – the charge for room and board in a lawfully operated Hospital, up to the amount shown in the Schedule of Benefits;

- Miscellaneous Hospital Services – the charge for all such services, except those not directly related to the treatment of the Covered Person;

- Surgery – the charges for all covered surgeries rendered by a legally qualified physician or surgeon for medical care and treatment to the Covered Person;

- Physician Services – the charges for all covered medical care and treatments performed on a Covered Person by a legally qualified physician or surgeon or other licensed provider. The Plan will not discriminate in its coverage based on the type of medical provider you use, such as a nurse practitioner rather than a doctor, as long as the provider is licensed to provide the service that you receive and the service is covered by the Plan;

- Dental Services - the charge for professional services rendered by a legally qualified dentist, physician or surgeon for the treatment of accidental injury to natural teeth within one year from the date of the accident;

- Professional Nurse Services – the charge for necessary special nursing services recommended and prescribed by the attending Physician and rendered by a registered graduate nurse, licensed practical nurse or nursing assistant, but excluding nursing services rendered by a member of the family or close relative of the Covered Person;

- Medical Services and Supplies – the charge for:

  - Drugs and medicines required and prepared from a Physician's prescription, provided that they are accompanied by a cash register receipt and not otherwise covered or excluded elsewhere;

  - Laboratory and X-ray services, including X-ray and radium treatment;

  - Anesthesia, oxygen, blood, plasma and surgical dressings;

  - Artificial limbs and eyes, casts, splints, trusses, braces and crutches;

  - Physiotherapy rendered by a legally-qualified physiotherapist, where Medically Necessary, but excluding physiotherapy services rendered by a member of the family or close relative of the Covered Person.

  - Local professional ambulance transportation to and from a Hospital, other than for Hospital outpatient treatment;

  - Hearing aids

  - Chiropractic modalities; and

  - Expenses in connection with the purchase or rental (up to the purchase price) of durable equipment.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edema).

MEDICAL BENEFIT EXCLUSIONS AND LIMITATIONS

The Plan does not cover the following services, except as otherwise provided under Preventive Services:

- Expenses related to a loss caused by, contributed to by, or resulting from dental care or treatment (except for the treatment of impacted teeth), or dental X-rays, or eye examinations for correction of vision or fitting of glasses, except as otherwise provided;

- Cosmetic surgery, unless the condition to be treated is a result of Injury or as required by the Women's Health and Cancer Rights Act;

- Medical examinations not connected with the care and treatment of an Injury or Sickness (except as otherwise provided);

- Supplies and services for which no charge is made, or which are furnished by or at the expense of the U.S. government or any of it agencies, including benefits paid under Medicare;

- Medical expenses caused or contributed to by warfare, Injury or Sickness contracted while in the armed forces, suicide or attempted suicide, self-inflicted Injury, aviation accidents (other than regular commercial flights), Injury or Sickness covered by Workers' Compensation or Occupational Disease Law;

- Organ transplants, unless:

  - The transplantation is not considered experimental or investigational (other than an Approved Clinical Trial) as determined by a Fund-designated medical/surgical consultant; and

  - The patient is admitted to a transplant center program at an established transplant facility; in which case the following payment rules apply:

  - The Fund pays expenses of an Employee, Retiree or Dependent while eligible for benefits under the Plan if the expenses are related to the transplantation of an organ, patient and donor screening, organ procurement, transportation of the organ, follow-up care in the home or Hospital, or immunosuppressant drugs up to the amount payable under the Schedule of Benefits covering the Employee, Dependent or Retiree;

  - The Fund pays live donor expenses up to the amount payable under the Schedule of Benefits covering the Employee, Retiree or Dependent; provided, however, that if the live donor has other group insurance coverage for such expenses, the Fund pays such expenses only as a secondary payer; and

  - The Fund in no event pays expenses for transportation of surgeons or family members or expenses related to any transplant that is not performed at an established transplant facility.

- In vitro fertilization or infertility-related procedures;
- Custodial care, rest cures, nursing home or convalescent home confinement;
- Experimental or educational services or supplies, other than an Approved Clinical Trial;
- Learning disabilities or mental retardation;
- Orthopedic shoes (except when joined to braces) or supportive devices for the feet, including orthotics and callus or corn paring;
- Temporomandibular joint dysfunction (TMJ);
- Speech or occupational therapy (except rehabilitation treatment following stroke or Injury), myofunctional therapy, or pulmonary rehabilitation;
- Replacement or repair of prosthetic device;
- Charges for services related to weight control and treatment of obesity, including gastric by-pass or other treatments and/surgeries of a similar nature;
- Hypnotism, biofeedback, stress management, and goal-oriented behavior modification therapy;
- Travel and lodging, whether or not recommended by a Physician;
- Any charges related to the pregnancy, childbirth, abortion, or miscarriage on the part of an Eligible Dependent other than the Eligible Participant or spouse, except as otherwise provided under Preventive Services, Appendix A;
- Charges for an elective abortion, except for a life threatening complication of pregnancy for the Eligible Participant or Spouse;
- Failure to appear for a scheduled appointment or office visit or for completing or furnishing medical documents or claim form;
- Work-related or routine physical examination, except those examinations covered under Preventive Services;
- Nonprescription drugs, vitamins, minerals, laetrile, enzymes, diet foods, and dietary supplements except as covered under Preventive Services.
- Private duty nursing care or other medical care provided by an individual who ordinarily resides in your or your Eligible Dependent's home and is related to you or your Eligible Dependent by blood or marriage;
- Therapeutic devices or appliances, except as otherwise provided;

- Acupuncture;

- Expenses related to dentistry, unless otherwise provided (see *Dental Benefits*);

- Vision care, including eye refraction, fitting of glasses or contact lenses, except as provided under *Vision Benefits*);

- Items subject to the *General Exclusions Applicable to All Benefits.*

The term "member of the family" or "close relative" as used above in connection with a registered graduate nurse and a legally qualified physiotherapist consist of the Covered Person's spouse, child, brother, sister or parents or parents-in-law.

An expense or charge shall be deemed to be incurred on the date on which the particular service or supply that gives rise to the expense or charge is rendered or obtained.

HOSPITAL ADMISSIONS

IF YOU PLAN TO BE ADMITTED TO THE HOSPITAL FOR ANY NON-EMERGENCY PROCEDURE, YOU OR YOUR PHYSICIAN MUST CONTACT THE UTILIZATION REVIEW FIRM FOR ADVANCE APPROVAL OF THE HOSPITAL CONFINEMENT. FAILURE TO CONTACT THE UTILIZATION REVIEW FIRM MAY RESULT IN A REDUCTION IN THE BENEFITS PAID. YOUR MEDICAL IDENTIFICATION CARD CONTAINS THE APPROPRIATE PHONE NUMBERS OR CONTACT THE FUND OFFICE.

FOR EMERGENCY ADMISSIONS CALL WITHIN 48 HOURS, OR AS SOON AS POSSIBLE TO ADVISE THE UTILIZATION REVIEW FIRM OF THE SITUATION.

IF HOSPITAL CONFINEMENT IS NOT APPROVED, OR, IF YOU ARE HOSPITALIZED WITHOUT PRE-AUTHORIZATION AND HOSPITALIZATION CANNOT LATER BE JUSTIFIED, THE FUND WILL NOT PAY FOR ROOM AND BOARD CHARGES.

VERIFICATION OF ELIGIBILITY

The hospital may request advance verification of your eligibility prior to your admission. Eligibility for inpatient hospital benefits can be verified by telephone in advance. Provide the hospital with the full name of the Participant, the full name of the patient, the Participant's social security number, Local Union affiliation and/or number, as well as the Fund's telephone number.

HOSPITAL CONFINEMENT

Room and Board--Benefits are payable at 80% of the PPO allowance up to the annual out-of-pocket maximum. After the out-of-pocket maximum is satisfied, benefits are then increased to 100% of the PPO allowance for all approved admissions in a calendar year.

Ancillary Services--During a period when room and board benefits are payable, all necessary hospital expenses incurred are payable at 80% of the PPO allowance up to the annual out-of-pocket maximum. After the out-of-pocket maximum is satisfied, benefits are then increased to 100% of the PPO allowance for all approved admissions in a calendar year.

NEWBORN AND MOTHER HEAL PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a 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, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

OUTPATIENT SERVICES

EMERGENCY ACCIDENT OR ILLNESS

Emergency Expenses are those incurred at a hospital emergency room or ambulatory care center for an emergency medical condition, which a person would reasonably consider medically necessary to stop or relieve a serious illness, injury or symptom, a serious impairment to bodily functions, or a serious medical condition needing immediate diagnosis and treatment. Emergency medical conditions include both medical and mental health conditions. Examples include but are not limited to severe breathing problems, convulsions, severe pain including chest pain, seizures, unconsciousness, serious eye injuries, extreme bleeding, head injuries and broken bones. Emergency services include a medical screening examination, evaluation and further medical treatment as required to stabilize the patient.

Emergency expenses are payable at 80% of any PPO allowance up to the annual out of pocket maximum if you are taken to a PPO network facility and receive services from network providers.. If you are taken to a hospital in a medical emergency and the facility, the attending physician and/or ancillary care providers do not participate in the PPO networks, benefits will be paid at 80% of the Usual & Customary (UCR) allowance. After your out of pocket maximum is satisfied, benefits increase to 100% of any PPO allowance or 100% of the UCR allowance for all approved admissions in the calendar year.

OUTPATIENT ILLNESS

Benefits are not payable with respect to hospital expenses incurred at a hospital emergency room or ambulatory care center for a non-emergency illness or condition.

NONEMERGENCY OUTPATIENT SURGERY

When hospital confinement is not necessary and nonemergency surgery is performed either in a Network hospital or an ambulatory care center, all related hospital service charges will be paid at 80% of the PPO allowance up to the annual out-of-pocket maximum. After the out-of-pocket maximum is satisfied, benefits are then increased to 100% of the PPO allowance for all approved admissions in a calendar year. All nonemergency outpatient surgery performed in a non-PPO hospital or ambulatory care center, including all related hospital service charges, will be paid at 50% of the UCR. Out of pocket maximums do not apply to nonemergency medical services provided outside of the PPO Network.

If outpatient surgery is performed in a PPO Network doctor's office, all related hospital-type service charges will be paid at 80% of the PPO allowance up to the annual out-of-pocket maximum. After the out-of-pocket maximum is satisfied benefits are then increased to 100% of the PPO allowance for all approved admissions in a calendar year.

Nonemergency outpatient surgery performed in an Out-of-Network doctor's office will be paid at 50% of the UCR. Out of pocket maximums do not apply to nonemergency surgical benefits provided outside of the PPO Network.

AMBULANCE

After the deductible is met, expenses for the professional local ambulance service to and from the Hospital in the situation of a medical emergency will be paid at 80% of the PPO allowance up to the annual out-of-pocket maximum. After the out-of-pocket maximum is satisfied, benefits are then increased to 100% of the PPO allowance for all approved admissions in a calendar year.
This benefit is payable as long as Hospital room and board benefits are payable for the Hospital confinement and the expense is shown to be Medically Necessary.

PREVENTIVE SERVICES

Preventive Services are covered by the Plan at 100% of the PPO Allowance when provided by PPO service providers. Preventive services include several types of health screenings and immunizations. See Appendix A to this document for a complete list of currently covered Preventive Services for Adults, for Women (including prenatal coverage) and for Dependent Children up to age 19. Please note that the list of covered Preventive Services will be updated by the Plan from time to time in the future.

Preventive Services for Adult participants are limited to one annual office visit (other than for prenatal coverage and separate Preventive Services for women). There is no limit on the number of office visits for Preventive Services for Dependent Children up to age 19. If your Provider does not bill a Preventive Service separately from an office visit, and the primary purpose of the visit is the delivery of a Preventive Service, you will not be charged a deductible or co-payment for the office visit. If, however, the Preventive Service is not the primary purpose of the visit, you will be charged for the office visit.

MENTAL ILLNESS, PSYCHONEUROSIS, PERSONALITY DISORDERS AND SUBSTANCE ABUSE

Psychiatric Care benefits provide payment for treatment rendered in connection with the following:

- Mental disorders
- Psychoneurotic/personality disorders
- Substance abuse, including alcoholism and narcotic addictions

Benefits for both inpatient and outpatient treatment are available. Benefits will be paid up to the maximum amounts shown in the Schedule of Benefits.

HOSPICE CARE BENEFITS

Hospice Care benefits are provided to terminally ill Covered Persons and their families, up to the maximums shown in the Schedule of Benefits, if the patient's Physician certifies that he or she is terminally ill, is no longer receiving curative treatment and has a life expectancy of six months or less. Benefits are payable for all inpatient and outpatient services rendered by a Hospice Center, provided that the services are not separated by a period of three months or longer. If the Hospice Center treatments are separated by a period of three months or more, each treatment is considered a new period of care.

A Hospice Center is a licensed public or private health care organization that provides coordinated 24-hour services for: nursing care by or under the supervision of a registered nurse; physical or respiratory therapy; medical social services (under the direction of a Physician); home health care by a trained aide; medical supplies (including drugs and biologicals); the use of medical appliances; Physician's services; short-term inpatient care for acute level care, pain control, symptom management and to provide respite care for family members; and counseling (including dietary and bereavement) with respect to care and adjustment to the patient's death.

Outpatient treatment charges are payable for services provided by a Physician, registered nurse, social worker, psychologist, physiotherapist, and/or respiratory therapist.

Benefits are payable to the patient's immediate family members for bereavement counseling within three months of the patient's death.

No Hospice Care benefits are payable for care provided by members of the patient's family, persons who normally live with the patient or individuals who do not normally charge for their services.

PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits provide payment for eligible prescription drug charges. This benefit is payable after the prescription drug co-payment or co-insurance (as applicable) is satisfied. There is no deductible for Prescription Drug benefits.

Mandatory Generics Preferred Program

A mandatory Generics Preferred Program is included as part of your Prescription Drug Coverage. Under this program, you will be required to use the generic version, if available, for all of your prescription needs. **If a Brand name drug is dispensed, either by direction of your physician or by your choice, you will be required to pay the difference in cost between the purchased medication and its generic equivalent, plus the co-pay or co-insurance, as applicable.**

SCHEDULE OF BENEFITS

Prescription Drugs for Active Participants and their Dependents

Retail (Pharmacy) co-payments
- Generic ..... $ 0
- Preferred or Formulary Brand $45
- Non-Preferred or Non-Formulary Brand $75

Maximum supply per purchase 90-days

Mail Order co-payments
- Generic ..... $ 0
- Preferred or Formulary Brand $50
- Non-Preferred or Non-Formulary Brand $90

Maximum supply per purchase 90-days

Annual Out of Pocket Maximum……..$3,000 for an individual
$6,000 for a family

Once the annual out of pocket maximum for Prescription Drugs has been met, the Fund will pay 100% of Prescription Drug costs for the remainder of the year.

Prescription Drugs for Retirees and their Eligible Dependents or Surviving Spouses Who Are Not Entitled to Medicare

Retail (Pharmacy) co-insurance
- Generic ..... $ 0
- Preferred or Formulary Brand 25%
- Non-Preferred or Non-Formulary Brand 25%

Maximum supply per purchase 90-days

Mail Order co-insurance
- Generic ..... $ 0
- Preferred or Formulary Brand 25%
- Non-Preferred or Non-Formulary Brand 25%

Maximum supply per purchase 90-days

Annual Out of Pocket Maximum……..$3,000 for an individual
$6,000 for a family

Once the annual out of pocket maximum for Prescription Drugs has been met, the Fund will pay 100% of Prescription Drug costs for the remainder of the year. If an individual family member has met the individual out of pocket maximum for the year, then the Fund will pay 100% of Prescription Drug costs for that individual only, even if the out of pocket maximum has not been met for the family.

Prescription Drugs for Retirees and their Eligible Dependents or Surviving Spouses Who Are Entitled to Medicare

If you are entitled to Medicare, you must sign up for Medicare Part D and a Medicare prescription drug program in order to continue your Prescription Drug Coverage. The Plan will provide you with a subsidy to help you pay for your Medicare prescription drug program, if you provide timely written documentation of having purchased such coverage. Please contact the Fund Office as soon as you become Medicare eligible.

Once you have exhausted your initial coverage limit under Medicare Part D, and/or have reached the "donut hole", you will be provided with 100% coverage for all prescriptions filled with a Generic drug through your supplemental coverage through Express Scripts. For all non-generic drugs, you will be required to pay 25% co-insurance plus the difference in cost between the purchased medication and its generic equivalent.

COVERED DRUGS

Covered drugs include:

- Drugs and medicines which can be obtained only by prescription and that bear the legend, "Caution, Federal Law Prohibits Dispensing Without a Prescription" when prescribed by a licensed doctor and not specifically excluded in the section *Exclusion and Limitations*.

- Insulin

Limitations on Quantity - Generally, the maximum amount or quantity of prescription drugs that will be considered as eligible charges may not exceed a 90-day supply when taken in accordance with the direction of the prescribing physician. However, the following drugs, dispensed in amounts of not more than 100 units (tablets, capsules, etc.), will be covered even though when taken in accordance with the prescriber's directions, such amount would exceed a 30 day supply;

- Nitroglycerin
- Phenobarbital
- Thyroid and synthetics
- Digitalis and derivatives
- Orinase
- Diabenese
- DBI, DBI-TD
- Dymelor
- Tolinase

Insulin may be prescribed in an amount not to exceed one vial.

Mail Order. A 90-day supply of standard maintenance medications may be obtained through the Mail Order program with the Prescription Benefit Manager. Contact the Fund Office for more information.

Advanced Utilization Management

Active participants and their families are required to participate in the Express Scripts Advanced Utilization Management Program, which includes step therapy, drug quantity management and/or prior authorization programs if their physicians prescribe certain medications. A sample of the most common is listed below. The Trustees reserve the right to add, modify or remove medications from the program as they consider financially prudent.

- Proton Pump Inhibitors, commonly used to treat gastric reflux disease (GERDs). (Nexium, Prilosec, etc.)

- Narcotics, such as Oxycontin, Vicodin, etc.

NEW VOLUNTARY PRESCRIPTION DRUG PROGRAM FEATURES

You may now participate in the following ***voluntary*** prescription drug features and programs in partnership with Express Scripts.

Voluntary Smart90 Program – 90 Day Supply of Maintenance Medications

You can now order a 90-day supply of maintenance medications at a discounted rate at either the Express Scripts mail order pharmacy or at your local CVS. The copay for these 90-day maintenance medications will remain the same regardless of whether the prescription is filled at CVS or via mail order. Shipping is free of charge.

The Smart90 program is completely voluntary. You can continue filling 30-day supplies of any medication at any in-network retail pharmacy without penalty. However, the broad retail pharmacy network is limited to filling a 30-day supply.

Voluntary Access to Accredo, the Express Scripts Specialty Pharmacy

The Plan will now utilize Accredo, the Express Scripts specialty pharmacy, as the Plan's preferred provider of specialty medicines. Specialty medicines are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and inflammatory conditions.

If you use specialty medications, you will pay less when purchasing those medications through Accredo. You can also use a pharmacy other than Accredo at the normal prescription cost under the Plan. If you fill your specialty prescriptions through Accredo, you will pay only the Plan's copayment while receiving a variety of specialty pharmacy services, such as access to a personalized team of pharmacists and nurses with specialty training on your medical condition. For convenience, some specialty medicine can be ordered online at express-scripts.com.

VoluntarySafeguardRx Programs

If you are currently taking medications for Hepatitis C, Cholesterol, or Cancer you will continue to fill these medications through the Express Script's specialty pharmacy, Accredo. If you are taking medications for Multiple Sclerosis or Inflammatory Conditions, which include conditions such as Rheumatoid Arthritis, Crohn's disease and Psoriasis, you will also begin filling these medications through Accredo. Members will have access to specialist pharmacists within each of Express Scripts' Therapeutic Resource Centers representing these chronic conditions.

You may access a specialist pharmacist by calling Express Scripts at the number listed on the back of the prescription card or by utilizing the click-to-call feature on the Express Scripts member website.

PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

The following charges are not covered for any class of participant**, except as otherwise provided under Preventive Services, Appendix A:**

- Charges not listed as covered prescription drug charges;
- Charges for medications used to treat penile dysfunction;
- Charges for a non-legend, patent or proprietary medicine or medication not requiring a prescription;
- Charges for immunizing agents, biological sera, blood or blood plasma, injectables or any prescription directing parental administration or use, except insulin, EPI-pens, and medications for the treatment of Hepatitis C and multiple sclerosis;
- Charges for vitamins, vitamin prescriptions (except pre-natal vitamins), cosmetics, dietary supplements, health or beauty aids;
- Charges for medication which is to be taken or administered to, in whole or part, the individual while he is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution;
- Charges for any drugs or medicines delivered or administered to the eligible individual by the prescriber;
- Charges for any drug labeled, "Caution-Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made to the individual, and except as otherwise used in Approved Clinical Trials;
- Charges for oral antibiotics in excess of 40 capsules or tablets per prescription;
- Charges for ointments or creams in excess of 4 ounces per prescription;
- Charges for contraceptives, contraceptive materials, contraceptive devices or infertility medication, except when prescribed by a physician to treat a medical condition (appropriate documentation will be required by the Fund Office)
- Charges payable under any of the other benefits of the plan to the extent of the portion of such charges so paid;
- Charges which are in the excess of the usual, regular and customary charges for the drug prescribed in the area in which the prescription is filled;
- Charges for any drug that this not medically necessary for treatment of the condition for which prescribed;
- Anorectics (any drug used for the purpose of weight loss)
- Fluoride Supplements

- Growth Hormones
- Minoxidil (Rogaine) for the treatment alopecia
- Smoking Deterrent Medications (Nicorette, Nicoderm, patches)
- Retin-A for individuals 26 years of age and older
- Therapeutic devices or appliances, including needless, syringes, support garments and other non-medical substances, regardless of intended use
- Charges for administration or injection of any drug
- Any prescription refilled in excess of the number specified by a physician, or any refill dispensed after one year from the physician's original order
- Charges subject to the *General Exclusions Applicable to All Benefits* as described herein.

DENTAL BENEFITS

The Plan pays for 80% of the Usual, Customary and Reasonable dental care up to an annual maximum of $1,000 per covered individual over the age of 18. There is no maximum limit for Dependent Children under the age of 19.

The amount of the benefit paid depends on the type of care or treatment provided as described below. The following dental care services are covered by the Plan.

PREVENTIVE CARE

The Plan pays 100% of the Usual, Customary and Reasonable Charges up to the annual maximum. Preventive Care consists of:

- Periodic Visits and Examinations –Limited to once every six months
- Emergency visits
- Prophylaxis, including scaling and polishing – Limited to once every six months
- Topical applications of fluorides– Limited to once every twelve month period
- Emergency palliative treatment
- Consultation by specialist when diagnosis has been made by a general dentist
- X-Rays and Pathology
  - Single films (up to 13)
  - Panorex – Limited to once every year
  - Entire denture series (14 or more films (limited to once every year))
  - Bitewings
- Biopsy and examination of oral tissue
- Microscopic examination

RESTORATIVE SERVICES

The Plan pays 80% of the Usual, Customary and Reasonable charges up to the annual maximum. Restorative series consist of:

- Restoration (fillings):
  - Amalgam, silicate cement, plastic and composite
  - Restorations

- Oral Surgery (including local anesthesia):
  - Extractions
  - Incision and drainage of abscess
  - Alveoplasty with ridge extension
  - Suture, soft tissue Injury

- Periodontics:
  - Subgingival curettage, root planing
  - Provisional splinting
  - Gingivectomy

- Endodontics:
  - Pulp capping
  - Root canals
  - Apicoectomy

- Denture Repairs
  Space Maintainer, Fixed (bank type) and Removable

ORTHODONTICS

The Plan will pay 50% of the Usual, Customary and Reasonable charges for Orthodontics and other treatments or procedures designed to prevent or correct malocclusion of the teeth up to a lifetime maximum of $1,000 per adult. There is no maximum for dependent children under the age of 19.

MAJOR SERVICES

The Plan pays 80% of the Usual, Customary and Reasonable charges, up to the annual maximum. Major services include:

- Inlays and Crowns (not covered if teeth can be restored with a filling material)
- Crowns
- Pontics (artificial teeth)
- Removable Bridge – one piece casting, clasp attachment (all types), including pontics
- Maryland Bridge
- Dental implants
- Dentures (specialized techniques not eligible):
  - Complete upper or lower

- Partial dentures
- Denture reline
- Denture duplication (jump case)

Keep in mind that, since many dental conditions may be treated in more than one way, the Plan benefit is based on the least costly treatment that would provide a professionally satisfactory result, as determined by the Fund Office.

DENTAL BENEFIT EXCLUSIONS AND LIMITATIONS

No dental care benefits are provided for:

- Replacement of a lost, stolen, or broken prosthetic device;

- Appliances or restoration for the purpose of splinting, increasing vertical dimension or restoring occlusion;

- Dental services and supplies rendered solely for cosmetic purposes, unless required as a result of an accidental injury or unless specifically provided under another provision of this Plan;

- Appliances or their modification, crowns, bridges, or gold restorations for which the impression was made or the tooth was prepared before the patient was covered under the Plan;

- Temporomandibular joint dysfunction (TMJ)

- Treatment by anyone other than a dentist, except that cleaning, scaling, and polishing of teeth may be performed by a licensed dental hygienist, if such treatment is rendered under the supervision and direction of a dentist;

- Replacement of an existing partial or full denture, splint or fixed bridgework; crowns and/or inlays installed as multiple abutments; splints for periodontal treatment; or prosthetic appliances, fixed or removable, used as an adjunct to periodontal treatment, unless satisfactory evidence is presented to the Fund that the existing denture or bridgework was installed at least 36 month prior to its replacement and the prosthetic appliance, fixed or removable, is required to replace a lost natural tooth. Note: This exclusion does not apply to Dependent Children under age 19 as defined by this document;

- Drugs, medicines and supplies intended for personal hygiene use, such as toothpaste and cleaning devices;

- Dental sealants;

- Charges incurred for treatment provided after coverage ends, except charges for the following treatment that is already in progress when coverage terminates will be covered if completed within 30 days of the date coverage ends:

    - Appliances or their modification for which an impression was taken prior to termination of dental benefits;

- Crowns, bridges or gold restorations for which the tooth was prepared prior to termination of dental benefits; and

- Root canal therapy provided that the pulp chamber was opened prior to termination of dental benefits.

- Items subject to the *General Exclusions Applicable to All Benefits* as described herein.

VISION CARE BENEFITS

PROCEDURES TO OBTAIN VISUAL CARE UNDER THIS PROGRAM

- Obtain a listing of participating vision specialists by contacting the toll-free number listed on the Vision Benefit Manager's brochure.

- Contact the Vision Benefit Manager and select the Vision Specialist of your choice from the list of participating vision specialists.

- Telephone the vision specialist you or your eligible dependents have selected and make an appointment. Inform the vision specialist of your affiliation with the vision benefit manager.

- Keep the appointment. IF CANCELLATION IS NECESSARY, NOTIFY THE VISION SPECIALIST'S OFFICE AT LEAST 24 HOURS IN ADVANCE.

- The Vision Specialist will inform you or your eligible dependents what other appointments are necessary.

If you use a provider who is a member of the Vision Network, the Fund Office will pay the Vision Specialist directly for covered services. If the provider is not a member of the Vision Network, you may also be required to pay for your services in full and seek reimbursement from the Vision Manager. You may be required to pay additional amounts for any other vision services you receive that are not covered by the Plan as described below.

COVERED VISION SERVICES

The Plan covers the following vision services:

- Vision Exam - a survey of principal visual functions to determine the condition of you or your eligible dependents' vision. Vision exams are limited to one exam every 12 months per Covered Person.

- Visual Analysis - a visual analysis is provided whenever a covered person seeking care has visually connected symptoms or when the vision screening indicates the need for further care. Visual Analyses are limited to one complete visual analysis per Covered Person every 12 months. The visual analysis includes, but is not limited to:

- Case history
- Examination for pathology (disease) or abnormalities
- Job visual analysis
- Refraction
- Coordination measurements
- Near point visual functions analysis
- Visual field examinations
- Prescription of proper lenses if indicated
- Tonometry and/or field tests given for glaucoma for Participants over age 35 or if family history of glaucoma.

- Lenses and Frames - when the visual analysis indicates that lenses and/or frames are necessary for the proper visual health and welfare of a covered person, the lenses and/or frames will be supplied together with the necessary professional services. Such services include, but not limited to:

  - Prescribing and ordering proper lenses;
  - Assisting in the eligible employee's and his eligible dependents' selection of a frame where indicated;
  - Verifying the accuracy of the finished glasses;
  - Proper fitting and adjustment of the glasses;
  - Progress or follow-up work as necessary;
  - Subsequent adjustments of frames to maintain comfort and efficiency;
  - Consultation and instructions regarding vision problems;

Lenses for each Covered Person are limited to once every 12 months and frames are limited to once every 24 months.

VISION BENEFIT EXCLUSIONS AND LIMITATIONS

The following services and materials are not covered by the Plan and, if obtained, must be paid for by the patient directly to the vision specialist:

- Supplies and services provided more frequently than described in *Covered Vision Services*, above;

- Sun glasses, plain or prescription;

- Special procedures such as orthoptics, vision training, contact lenses used for cosmetic purposes, subnormal vision aids, aniseikonia, etc.;

- Medical or surgical treatment of the eyes. These are covered under existing medical and surgical benefits and any eligible employee and his eligible dependents found to be in need of such treatment will be referred to a specialist. NOTE: Laser vision correction is not covered by the plan, however you may receive a discount through the Vision Benefit Manager;

- Services or materials for which the patient may be compensated under the Workers' Compensation law or employer's liability law, regardless of jurisdiction; or services that the patient obtains without cost from any Federal government organization, county, municipality or special service district;

- Replacement of lost, stolen or broken glasses;
- The cost of photosensitive lenses in excess of the cost of clear lenses;
- All tints;
- The cost of designer and/or special frames;
- Items subject to the *General Exclusions Applicable to All Benefits* as described below.

GENERAL EXCLUSIONS TO ALL BENEFITS

(See additional specific exclusions for Medical, Prescription Drug, Dental and Vision benefits in their appropriate sections)

Benefits are not payable for charges in connection with:

- Occupational Injuries or Sickness, except as otherwise provided;
- Injuries or Sicknesses for which benefits are payable under a Workers' Compensation Law, occupational disease law or similar legislation whether or not the right for benefits is asserted (except Supplemental Weekly Disability Income Benefits). Where a workers' compensation claim is being actively contested, benefits may be paid if the Covered Person and his or her legal counsel have satisfied all obligations under the *Reimbursement and Subrogation* provisions of the Plan, including any obligations owed under a Reimbursement and Subrogation agreement.
- Military Service, or warfare or any act of war, whether declared or not;
- Injuries or Sicknesses resulting from or occurring because of a Covered Person's employment for wage or profit, if the employment is not Covered Employment;
- Self-inflicted Injuries, including suicide or attempted suicide (unless resulting from a diagnosed medical condition);
- Aircraft accidents, except while riding as a fare-paying passenger on a regularly scheduled airline flight;
- Confinement or services provided in a Veteran's Administration or other Federal, State, County or Municipal Hospital, unless otherwise required by law;
- Commission as a perpetrator of a felony or misdemeanor or other criminal activity;
- Participation in a riot.

COORDINATION OF HEALTH BENEFITS

COORDINATION WITH OTHER GROUP HEALTH PLANS

The Plan includes a coordination-of-benefits (COB) provision. This applies to people who are covered by other medical plans, including other employer plans, union plans and governmental plans. Under COB, one plan is considered "primary" and the other "secondary." The primary plan always pays first and usually pays full regular benefits. If you or any of your dependents are eligible to receive benefits from another group plan that is the primary plan, the benefits paid by the Fund may be reduced.

The primary plan is determined in the following order:

- A plan that covers the patient as an employee or retiree is primary and any plan that covers the patient as a dependent is secondary.

- Any plan that does not contain a coordination of benefits provision is primary.

- A plan that covers the patient as an active employee is primary and any plan that covers the patient as a retired or laid-off employee is secondary. A plan that covers the patient as a dependent of an active employee is primary and any plan that covers the patient as a dependent of a retired or laid-off employee is secondary.

- A plan that covers a person because of federal or state continuation-of-coverage laws, such as COBRA, is secondary to a plan that covers the person on any other basis.

- If the above rules do not apply, the plan that has covered the individual the longest period of time is usually primary.

SPECIAL RULES FOR DEPENDENT CHILDREN

There are special rules for determining the primary plan when the patient is a dependent child:

- If the patient is a dependent child whose parents are not divorced or separated, the plan of the parent whose birthday occurs earlier in the year is primary. For this purpose, the year of birth is not relevant.

- If the patient is a dependent child whose parents are divorced or separated, the plan of the parent who has been ordered by a court to provide health coverage for the patient is primary. If neither parent is under court order to provide health coverage, the plan of the parent who has custody of the dependent child is primary. The plan of the custodial parent's spouse is secondary, and the plan of the other natural parent is third.

- If the coordination-of-benefits as to primary or secondary coverage of a dependent child is set forth pursuant to a court order, then the court order shall be followed.

HOW BENEFITS ARE COORDINATED

The primary plan will pay your claim as if there is no other coverage involved. When the Fund is the secondary plan, it will make payments based on the balance left, if any, after the primary health care plan has paid or would have paid if a proper claim had been filed. The Fund will pay no more than that balance up to the amount it would have paid had it been primary.

The Fund will pay only for health care services that are covered under the plan and will pay no more than the "allowable expense" for the health care involved. An allowable expense means the necessary, reasonable and customary item of expense for health care when the item is covered at least in part under any of the plans involved. Allowable expenses do not include the amount of a benefit reduction under the primary plan because the patient does not comply with plan provisions, such as second surgical opinions, pre-certification of admissions or services, or preferred provider arrangements.

These rules apply only when another plan is primary and this plan is secondary. If the Fund is primary, its benefits are determined as if no other plan is involved; however, the secondary plan may pay additional benefits.

To ensure you receive the benefits to which you are entitled from both plans, it is important to submit your claims properly. For example, when you file a claim for your spouse, be sure to file under his or her plan first. After you have received payment from your spouse's plan, then you can submit for payment to this plan. When you submit a claim to the second plan, be sure to include the Explanation of Benefits (EOB) from the primary plan, as well as another copy of the bill.

To be eligible for coordination-of-benefits with this Plan, the Participant must adhere to all guidelines of the primary payer

COORDINATION WITH MEDICARE

The Plan coordinates with Medicare based on employment status and the reason for Medicare eligibility. Benefits for medical expenses for Retirees and their spouses who have reached age 65 will be coordinated with Medicare Parts A&B as described below. The Fund will be considered your "secondary" carrier. This means the Fund will only consider charges not paid by Parts A and B of Medicare up to the limits of the benefits as described in this booklet. There is no Loss of Time benefit from the Health Fund for the Retired Participant. **You must have both Parts A and B of Medicare in order for the Fund to make payment on your claims.**

YOU ARE ACTIVELY EMPLOYED AND YOU AND/OR YOUR SPOUSE ARE AGE 65 OR OLDER

Generally, as long as you continue to be actively employed, the Fund will be primary, with Medicare secondary. You may choose, however, to be covered only by Medicare. In that event, your coverage under the Health and Welfare Plan will end. Your covered spouse has the same options at age 65 no matter how old you are at that time.

YOU ARE RETIRED AND YOU AND/OR YOUR SPOUSE ARE AGE 65 OR OLDER

If you are retired and you and/or your spouse are age 65 or older, Medicare is primary and pays benefits first. The Fund then pays what it would normally pay, less the benefits that are provided by Medicare Part A and Part B (or that would have been paid by Medicare had you and/or your spouse enrolled for that coverage.)

You and your spouse should contact the Social Security Office regarding Medicare Part A and Part B at least three (3) months prior to attaining age 65.

YOU, YOUR SPOUSE OR YOUR DEPENDENT HAVE END-STAGE RENAL DISEASE

If you, your spouse or a covered dependent are eligible for Medicare due to end-stage renal disease, the Fund is primary during at least the first 30 months of dialysis treatment; after this initial period, Medicare will be primary and the Fund will be secondary.

YOU, YOUR SPOUSE OR DEPENDENT ARE DISABLED

A disabled individual under age 65 becomes eligible for Medicare if the disability is certified by the Social Security Administration and has lasted at least 24 months. If this applies to your spouse or a covered dependent, and you are actively employed, the Fund is primary and Medicare is secondary. Medicare will become primary when you are no longer actively working.

Note that if you are retired and your disabled spouse has other group coverage as an active employee, benefits are payable in the following order:

- The spouse's coverage is the primary payer,
- Medicare is the second payer,
- IUPAT District Council No. 51 Health Fund pays as third payer up to the limit of the benefits provided by the Fund.

DEATH BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

SCHEDULE OF BENEFITS

Death Benefit (Participants only)

Payable for death from any cause $5,000

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Accidental Death and Dismemberment (Participants only)

For accidental Death $5,000
For accidental loss of any two members (hands, feet, eyes).....$5,000
For accidental loss of any one member (hand, foot, eye) $2,500

The Death Benefit and Accidental Death and Dismemberment Benefit will only be payable on behalf of active and/or retired participants who satisfy the Eligibility requirements of the Plan as of the date of

their death or the date of their accidental dismemberment.

Death Benefits and Accidental death benefits are payable to the beneficiary you designate as shown in the Fund Office records. All other benefits are payable to you. If you name more than one beneficiary, and do not specify the amount of benefits to be paid to each, the benefits will be paid in equal shares or to the survivor. If you do not name a beneficiary, payment will be made to your widow or widower, if living; otherwise to your living children, if any; otherwise to your parents, if living; or, to your estate.

You may change your beneficiary without the beneficiary's consent by giving written notice to the Fund Office. The change will become effective the date you sign the notice. Contact the Fund Office for the appropriate form.

Your Accidental Dismemberment benefits are payable only to you, the Participant.

DEATH BENEFITS

Your death benefits are provided by the Fund and cover you both on and off the job. If you die while eligible for benefits, the amount of your death benefit insurance will be paid to your designated beneficiary.

You may not assign your death benefit.

FILING CLAIMS

Contact the Fund Office for the proper forms to be completed to file a claim for Death benefits. The procedures for submitting claims are set out in the *Claims Procedures for Death Benefit and Accidental Death and Dismemberment Benefits* section. Note that all claims for Death Benefits and Accidental Death and Dismemberment Benefits must be submitted to the Fund within 12 months from the date of death of the participant.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (AD&D)

Your Accidental Death and Dismemberment benefits are provided by the Fund and cover you on and off the job.

If you die or suffer the loss of a limb or sight as a result of and within 90 days of a covered accident the Plan will pay the benefit amount as shown in the *Benefit Schedule* above. No more than $5,000 will be paid for all losses resulting from a single accident.

The Fund Office should be notified of any loss within twenty (20) days after your accident. Written proof of your injury should be sent to the Trust Office within ninety (90) days. Contact the Fund Office for the appropriate forms. All claims must be submitted, with appropriate documentation, within 12 months of the injury.

Accidental Death claims are filed in the same manner as Death Benefit claims. Procedures are described later in this Summary Plan Description. All claims must be submitted, with appropriate

documentation, within 12 months of the injury.

DEATH BENEFIT AND AD&D BENEFIT EXCLUSIONS

The Plan will not pay for losses resulting from:

- Committing or attempting to commit an assault or felony,
- Self-inflicted injury,
- Insurrection or war,
- Participating in a riot,
- Disease of the body, mental infirmity, medical or surgical treatment or diagnosis, ptomaine, bacterial infection, poison, or asphyxiation from or inhaling gas.

FILING CLAIMS

Contact the Fund Office for the proper forms to be completed to file a claim for Accidental Death and Dismemberment benefits. The procedures for submitting claims are set out in the *Claims Procedures for Death Benefit and Accidental Death and Dismemberment Benefits* section.

DISABILITY INCOME/ LOSS OF TIME BENEFITS

SCHEDULE OF BENEFITS

Weekly Disability Income Benefit (Participants only)

Payable for non-occupational loss of time

Number of weeks payable per calendar year 26

Day coverage begins:

For Injury ..... 1st day

For Sickness ..... 8th day

Weekly Benefit:

1st thirteen weeks $400

Next thirteen weeks $300

Benefits will not be provided to participants who collect unemployment benefits during their periods of disability.

WEEKLY DISABILITY INCOME BENEFITS

Weekly Disability Income benefits are payable, up to the maximum shown in the *Schedule of Benefits* for any loss of earnings due to a non-occupational Injury or Sickness that results in your Disability. A non-occupational Injury or Sickness is one that does not occur as a result of, or in the course of, your employment and that is not covered under any workers' compensation law.

Benefits begin on the first day of Disability due to an Injury and on the eighth day of Disability due to Sickness, and continue for a maximum of 26 weeks during any one continuous period of Disability.

No Weekly Disability Income benefits are payable for any period of time that you are receiving a salary from any Employer, a Pension Benefit from the IUPAT Pension Fund or unemployment benefits or for any period of time that you are not under a Physician's care. No Weekly Disability Income benefits are payable if you are on COBRA or if your Eligibility is based on personal contributions currently being made by you. If you inadvertently receive benefits while you are also receiving a salary or pension, you must reimburse the Fund for any benefits you receive during that period.

Disability does not require you to be house-confined. However, you must be under the direct care of a Physician, as certified on a form supplied by the Fund Office. In order to certify your continued Disability, the Fund can require you to be periodically examined by a Physician.

CONTINUOUS DISABILITY -- NEW DISABILITY

A continuous period of disability includes all periods of disability due to the same or related cause or causes that are separated by less than two weeks of continuous, full-time, active work. Any subsequent disability will be considered a new disability irrespective of its cause or causes. Periods of Disability resulting from different or unrelated causes are considered separate periods of Disability, regardless of whether you return to work between each period of Disability.

FILING A CLAIM

Contact the Fund Office for the proper forms to be completed by the doctor who is treating you for your disability. The procedures for submitting claims are set out in the *Claims Procedures for Health and Disability Benefits* section.

CLAIMS PROCEDURES AND REVIEW OF POLICIES

CLAIMS PROCEDURES FOR HEALTH AND WEEKLY DISABILITY INCOME BENEFITS

ALL CLAIMS FOR BENEFITS MUST BE MADE WITHIN ONE YEAR OF THE DATE THE EXPENSE WAS INCURRED. A CLAIM FILED MORE THAN ONE YEAR AFTER THE EXPENSE WAS INCURRED WILL BE AUTOMATICALLY DENIED.

NOTE THAT NEITHER A CLAIMANT NOR HIS OR HER REPRESENTATIVE HAS A RIGHT TO A HEARING OR OTHER PERSONAL APPEARANCE AT THE FUND OFFICE OR BEFORE THE BOARD OF TRUSTEES TO PRESENT A CLAIM OR APPEAL.

CLAIM INQUIRIES

If you have a question regarding coverage for services not specifically described in the Summary Plan Description, submit it in writing to the Fund Office. **Do not rely on a verbal verification alone**--request a written statement before proceeding with the contemplated medical service. The Fund will not pay for non-covered charges unless it previously provided a written statement to a claimant that the medical service is covered and that statement is provided to the Fund upon its request.

TIMEFRAMES

The claims procedures contain various timeframes within which the claimant must file a claim or appeal and within which the Fund or the Board of Trustees must issue a decision on such claim or appeal.

The Fund or the Board of Trustees may agree to extend the time limits applicable to a claim and the claimant may agree to extend any time limit within which the Fund or the Board of Trustees must issue a decision. Any agreement to extend an applicable time limit must be knowing, explicit and confirmed in writing before such time period expires.

APPLICABLE DEFINITIONS

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

- A **pre-service claim** is a claim for a benefit that requires prior approval under the terms of the plan, such as inpatient admission pre-certification and other pre-certifications described in the summary plan description.

- An **urgent care claim** is a type of pre-service claim which, if the regular time periods for handling pre-service claims were followed: (1) could seriously jeopardize your life or health or your ability to regain maximum function or (2) would, in the opinion of a health care provider with knowledge of your condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject to the claim.

- A **post-service claim** is a claim for a benefit that does not require prior approval under the terms of the plan. A post-service claim involves a claim for payment or reimbursement for medical care or supplies that have already been received.

- A **disability claim** is a claim for benefits that may be payable based upon a determination that you are unable to work, such as Weekly Disability Income/Loss of Time Benefits. Disability claims will generally be handled like post-service health benefit claims; however, there are some special time periods that apply to processing a disability claim.

SUBMITTING INITIAL CLAIMS FOR BENEFITS

Pre-service and urgent care claims. A pre-service claim, including an urgent care claim, will be considered submitted when a request for pre-certification is received by American Health Holdings at 1-800-641-5566.

Incorrectly submitted claims. If the plan's procedures for filing a pre-service claim are not followed, you or your health care provider will be notified of the appropriate procedures if:

(1) the request for prior approval was received by someone who customarily is responsible for handling benefit matters and (2) the communication identifies the claimant, the specific treatment, service or product for which approval is requested and the medical basis for the request. Notice of an incorrectly submitted claim will be provided no more than 24 hours (for urgent care claims) or

five calendar days (for all other pre-service claims) after the incorrectly submitted claim is received. This notice may be oral unless you request written notification.

Post-service claims. PPO providers will generally submit their claims for payment directly to CareFirst. If you obtain services from a provider who is not affiliated with Carefirst, you must pay for the services and submit a claim for reimbursement to:

IUPAT District Council No. 51 Health Fund
c/o Zenith American Solutions
401 Liberty Avenue
Suite1200
Three Gateway Center
Pittsburgh, PA 15222
(412) 471-2885 or toll free (800) 242-8923

A claim for services may be filed with the Fund Office by use of a generic claim form, an itemized bill or the Fund's customized Statement of Claim form. Whichever method is used, please note that all formats must contain the following information:

- Name, address and federal ID number of physician, supplier of service, or dentist;
- Name, address of the patient;
- Social Security number of the *participant*;
- Group number or name of the participant's Union
- Date each service was performed
- Charge for each service;
- Procedural code and/or description of each service;
- Diagnosis.

When submitting your claim, you must submit an original of the bill. Photocopies of bills are not acceptable except under the following circumstances:

- When other group insurance is involved and the Fund is the secondary payer;
- The billing is a physician's itemized, running list of all charges and payments;
- The original bill has been lost. If this is the case, the photocopy must be submitted with a signed statement by the participant that the original was lost.

When submitting a claim for "Secondary" payment you must attach a copy of the other insurance's explanation of benefits to the claim. This information is necessary to process your claim; without this information the processing of your claim will be delayed.

Disability claims. You should submit a claim for Weekly Disability Income Benefits to the Fund Office.

Weekly Disability Income/Loss of Time Benefits. Your initial claim for Weekly Disability Income/Loss of Time Benefits should be made as soon as possible, even though benefits may not be payable immediately. Refer to the section *Weekly Disability Income/Loss of Time Benefits* for additional details.

Complete and sign Part 1, 2 and/or 3 of the disability claim form, then have your attending physician complete and sign Part 4, including the estimated length of your disability. Claims for continuation of Weekly Disability Income/Loss of Time Benefits should be filed at regular intervals thereafter, as required by the Fund Office, as long as you are disabled and benefits remain to be paid. Medical forms for continuation of loss of time benefits must always be completed by you and your attending physician.

INITIAL CLAIMS DETERMINATIONS

The timeframes for making the initial decision regarding a claim and the procedures for notifying you about that decision depend on the type of claim.

Urgent care claims. You will be notified whether your urgent care claim has been approved or denied as soon as possible, but in no event later than 72 hours after the claim is received. If more information is needed in order for a determination to be made, you will be advised of the specific information necessary to complete the claim within 24 hours after receipt of the claim. You will be allowed at least 48 hours to provide the necessary information. You will be notified of the determination within 48 hours after the earlier of: (1) the plan's receipt of the requested information or (2) the end of the period you were given in which to provide the information. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

Pre-service claims. You will be notified whether your pre-service claim has been approved or denied within a reasonable period of time appropriate to the medical circumstances involved, but in no event more than 15 days after the claim is received. The 15-day period may be extended an additional 15 days if the extension is necessary due to matters beyond the control of the plan and you are notified of the extension before the initial 15-day period expires. If the extension is required because you failed to submit information necessary to decide the claim, the extension notice will specifically describe the information needed to complete the claim. You will be given at least 45 days from the time you receive the notice to provide the requested information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

Previously approved treatments

- If the Plan previously approved an ongoing course of treatment that was to be provided over a period of time or that involved a specified number of treatments and you wish to extend the course of treatment beyond that which had been approved, you may request an extension.
  If the claim involves urgent care, you will be notified whether the extension has been approved or denied no more than 24 hours after your request for the extension is received, provided that you make such request at least 24 hours before the end of the previously approved period of time or before you received all of the previously approved treatments. If the request for an extension is made less than 24 hours before the expiration of the prescribed period of time or number of treatments, the request will be treated as a new urgent care claim and decided under the general timeframe applicable to urgent care claims. If the claim does not involve urgent care, the extension request will be treated as a new pre-service claim and will be decided within the timeframe applicable to pre-service claims as described above.

- If the Plan previously approved an ongoing course of treatment that was to be provided over a period of time or that involved a specified number of treatments, any decision by the plan to reduce or terminate that course of treatment (other than by plan amendment or termination) before the end of such period of time or before all approved treatments have been received will be considered a benefit denial. You will be notified sufficiently in advance of such reduction or termination to allow you to appeal and obtain a determination on the appeal before the benefit is reduced or terminated.

Post-service claims. You will be notified of the decision on your post-service claim within a reasonable period of time, but not later than 30 days after the claim is received. This time period may be extended for an additional 15 days when necessary due to matters beyond the control of the plan or if your claim is incomplete. You will be advised in writing of the need for an extension during the initial 30-day period and a determination will be made no more than 45 days after the date the claim was submitted. If the extension is needed because your claim is incomplete, the notice will specifically describe the information needed to complete the claim and you will be allowed 45 days from receipt of the notice to provide the information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to such notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

Disability claims. You will be notified of the decision on your disability claim within a reasonable period of time, but not later than 45 days after a claim is received. This time period may be extended for an additional 60 days, in the form of two 30-day extensions, when necessary due to matters beyond the control of the Fund. You will be advised in writing of the need for an extension during the initial 45-day period and you will be notified of the need for a second extension of time before the end of the first extension period. The notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and any additional information needed to resolve those issues.

You will be allowed 45 days from receipt of the notice to provide any additional requested information. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

IF YOUR CLAIM IS DENIED

If your claim for a benefit is denied in whole or in part, you will receive a written notice that will provide:

- A discussion of the specific reason or reasons for the denial, and a description of any standard (such as "medical necessity") used in denying the claim.
- Sufficient information to identify the claim including the date of service, health care provider and claim amount.
- An offer to provide relevant diagnosis and treatment codes (and the corresponding meanings of those codes), upon request and free of charge.
- Reference to specific plan provisions on which the determination was based.
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary.

- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim (including through a request for external review), including:
  - Your right to submit written comments and have them considered,
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and
  - Your right to bring a civil action under Section 502 of ERISA if your claim is denied following external review.
- If an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim:
  - A description of the specific rule, guideline, protocol or criterion relied on, or
  - A statement that a copy of such rule, guideline, protocol or criterion will be provided free of charge upon request.
  –
- If the basis for the denial was medical necessity or a determination of experimental or investigational treatment or similar exclusion or limit:
  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your circumstances, or
  - A statement that such an explanation will be provided free of charge upon request.
- In the case of a denial of an urgent care claim, a description of the expedited review process applicable to such claim.
- Contract information for any state Consumer Assistance program, if available in your state, to assist you with your internal appeal.

REVIEW OF DENIED CLAIMS

You have 180 calendar days after receiving notice that your claim has been denied in whole or in part in which to appeal the determination.

Urgent care and pre-service claims. Appeals of decisions involving urgent care claims and pre-service claim appeals (e.g. claims pertaining to pre-certification for admission to hospital, rehabilitation facilities, skilled nursing facilities or for case management, etc.) should be submitted to:

American Health Holdings
1-800-641-5566

Post-service claims and disability claims. Appeals of decisions involving post-service claims should be submitted to:

Board of Trustees
IUPAT District Council #51 Health & Welfare Fund
c/o Zenith American Solutions
3 Gateway Center
401 Liberty Ave., Ste. 1200
Pittsburgh, PA 15222-1024

Appeals of urgent care claims and first-level pre-service claim appeals may be submitted in writing or orally. Appeals of post-service claims must be in writing.

Your appeal should set out the reasons you believe that the claim should not have been denied and should also include any additional supporting information, documents or comments that you consider appropriate.

At your request, you will be provided with reasonable access to, and copies of, all documents, records, and other information relevant to the claim, free of charge. You may also request the plan to identify any medical or vocational expert from whom it received advice in connection with the benefit determination, regardless of whether it relied on such advice in making the initial benefit determination.

You will be provided, free of charge, any new or additional evidence considered, relied upon or generated by, or at the direction of the plan in connection with your appeal. You will also be provided, free of charge, any new or additional rationale that is used in responding to your claim. You shall receive such information regarding the new or additional evidence or rationale sufficiently in advance of the time limit for the plan to respond to your appeal to allow you a reasonable opportunity to respond before that plan deadline.

Expedited procedures for urgent care claims. You may request an expedited appeal of a denial involving an urgent care claim. This request may be oral or in writing.
Under these expedited procedures, all necessary information, including the determination on appeal, may be transmitted by telephone, facsimile or other available similarly expeditious method. The phone number for initiating an expedited appeal is provided above.

DETERMINATIONS ON APPEAL

The timeframe for making a decision on the appeal depends on the type of claim:
Urgent care claims. You will be notified of the determination on appeal as soon as possible, taking into account the medical urgency of the situation, but in no event more than 72 hours after your appeal is received.

Pre-service claims. You will be notified of the decision on appeal within a reasonable period of time but no longer than 15 days after it is submitted. If you are not satisfied with the decision, you have the right to file a second level appeal with the Board of Trustees.

Your second level appeal request must be submitted within 60 days from receipt of first level appeal decision and must be in writing. Appeals should be submitted to the Board of Trustees at the address shown above. You will be notified of the decision on your second-level appeal no more than 15 days it is submitted.

Post-service claims and disability claims. The Board of Trustees or a designated subcommittee of the Trustees will review and decide your appeal at the quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In that event, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special

circumstances require a further extension of time for review, the decision on appeal will be rendered not later than the third Trustees' meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision**.** You will receive written or electronic notice of the decision of the trustees after review by the Trustees within 5 days of the date the decision is made. If the Trustees need more information from you, their time for making a decision on your appeal will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request.

The review on appeal will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination or at a lower level of appeal. The review will not give deference to the initial denial or, if there is more than one level of appeal, to the decision at a lower level of appeal. In addition, the individual who decides your appeal will not be the same individual who initially decided your claim or made a decision at a lower level of appeal and will not be that individual's subordinate.

A health professional may be consulted in deciding your appeal, except that any health professional consulted in connection with your appeal will not have been involved in the initial benefit determination or at a lower level of appeal nor be a subordinate of the health professional who was involved.

Except in instances in which notice is provided pursuant to the expedited procedures for urgent care claims described above, you will be notified in writing of the decision on appeal. If the decision upholds the denial of your claim, the notification will provide:

- A discussion of the specific reason or reasons for the denial, and a description of any standard (such as "medical necessity") used in denying the claim

- Sufficient information to identify the claim including date of service, health care provider and claim amount.

- An offer to provide relevant diagnosis and treatment codes (and the corresponding meanings of those codes), upon request and free of charge;

- Reference to specific plan provisions on which the determination was based. A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

- If the denial was based on medical necessity or a determination of experimental or investigational treatment or similar exclusion or limit:
  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your circumstances; or
  - A statement that such an explanation will be provided free of charge upon request.

- If an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim:
  - A description of the specific rule, guideline, protocol or criterion relied on, or
  - A statement that a copy of such a rule, guideline, protocol or criterion will be provided free of charge upon request.

- A statement of the external review processes available, including information on how to initiate an external appeal.

- A statement of your right to bring a civil action under Section 502 of ERISA.

- Contact information for any state Consumer Assistance Program, if available in your state, to assist you with external review processes.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. Generally, this authorization must be in writing and signed by you; however, in the case of an urgent care claim, a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law and who has knowledge of your medical condition will be acknowledged as your authorized representative even if no written designation is submitted. Any reference in these claims procedures to "you" is intended to include your authorized representative.

An assignment to a health care provider for purposes of payment does not constitute appointment of an authorized representative under these claims procedures.

EXTERNAL REVIEW:

Upon exhaustion of the Plan's internal review process, you have a right to seek an external review of any claim denial based on medical necessity, appropriateness, health care setting, level of care or effectiveness of the covered benefit. However, exhaustion of the internal review process shall not be required if: (a) the Plan waives the exhaustion requirement; (b) the Plan fails to comply with the requirements of the internal appeals process except as to failures that are based on de minimus violations that do not cause, and are not likely to cause, prejudice or harm to you; or (c) you simultaneously request an expedited internal appeal and an expedited external review.

The external review shall be by independent health care professionals ["IRO"] qualified to address your claim. The Plan shall make a rotational assignment to one of at least three qualified IROs available for such external reviews, to ensure impartiality in the assignment process. The IRO decision will be binding on you, as well as the Plan.

You may submit a request for external review within four (4) months after you receive notice of the final internal adverse benefit determination to:

ATTN: EXTERNAL REVIEW REQUEST
IUPAT District Council #51 Health & Welfare Fund
c/o Zenith American Solutions
3 Gateway Center
401 Liberty Ave., Ste. 1200
Pittsburgh, PA 15222-1024

Requests for external review of urgent care claims and of first-level pre-service claim may be submitted in writing or orally. All requests regarding post-service claims must be in writing.

Your request should include the reasons you believe that the claim should not have been denied and should also include any additional supporting information, documents or comments that you consider appropriate in the IRO's consideration of your claim. You shall have at least 5 business days after requesting external review to submit additional information.

In pursuing a request for external review, you will be required to sign a written release of any medical records that may be required to be reviewed by the IRO for purposes of reaching a decision on the external review.

At your request, you will be given reasonable access to, and copies of, all documents, records, and other information relevant to the claim, free of charge. You may also ask the plan to identify any medical or vocational expert from whom it received advice in connection with the benefit determination, regardless of whether it relied on that advice in making the initial benefit determination.

In normal circumstances, a decision will be made within 45 days if receiving your request for review.

Expedited procedures for urgent care claims. You may request an expedited external review of the denial of an urgent care claim appeal. This request may be oral or in writing. Under these expedited procedures, all necessary information, including the determination on external review, may be transmitted by telephone, facsimile or other available similarly expeditious method. The phone number for initiating an expedited request for external review is 301-839-8800.

In the case of urgent care claims, the IRO will provide notice of its decision as quickly as possible, but no later than 72 hours after its review of your request for external review.

FRAUDULENT CLAIMS

If a fraudulent claim is knowingly submitted, all benefits claimed will be denied. If any benefits are paid in connection with a fraudulent claim, the Participant and his dependents will not receive further benefits under the Fund until the money improperly obtained is returned to the Fund. The Participant will be advised by mail of any action taken with regard to a fraudulent claim.

PRESCRIPTION DRUG COVERAGE REVIEWS, APPEALS, AND EXTERNAL REVIEWS

Express Scripts will handle initial coverage reviews, appeals, and requests for external reviews (when applicable) pertaining the Plan's prescription drug benefits only.

Initial Coverage Review

A member has the right to request that a medicine be covered or be covered at a higher benefit (such as a lower copay or higher quantity). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests.

How to Request an Initial Coverage Review

To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at express-scripts.com/PA.

To request an initial administrative coverage review, which involves a request for coverage of a medication that is based on the Plan's benefit design, the member or his or her representative must submit the request in writing using a Benefit Coverage Request Form, which can be obtained by calling the Customer Service phone number on the back of the prescription card.

Complete the form and fax it to 877.328.9660 or mail to:
Express Scripts
Attn: Benefit Coverage Review Department
P.O. Box 66587
St Louis, MO 63166-6587

If the patient's situation meets the definition of urgent under the law, an **urgent review** may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of the request.

If the patient or provider believes the patient's situation is urgent, the provider must request the expedited review by phone at 800.753.2851.

How to Request a Level 1 Appeal or Urgent Appeal if an Initial Coverage Review is Denied

When an initial coverage review has been denied, also referred to as an adverse benefit determination, a request for appeal may be submitted by the member or authorized representative **within 180 days** from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests can be faxed to 877.852.4070 or mailed to the following address:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588

Administrative appeal requests can be faxed to 877.328.9660 or mailed to the following address:

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587

If the patient's situation meets the definition of urgent under the law, an **urgent appeal** may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent:

Urgent Clinical Appeal Requests
Phone: 800.753.2851 Fax: 877.852.4070

Urgent Administrative Appeal Requests
Phone: 800.946.3979 Fax: 877.328.9660

How to Request a Level 2 Appeal if a Level 1 Appeal is Denied

When a level 1 appeal has been denied, also called an adverse benefit determination, a request for a level 2 appeal may be submitted by the member or authorized representative **within 90 days** from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests can be faxed to 877.852.4070 or mailed to the following address:

Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588

Administrative appeal requests can be faxed to 877.328.9660 or mailed to the following address:

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587

If the patient's situation meets the definition of urgent under the law, an **urgent appeal** may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent:

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Urgent Administrative Appeal Requests
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Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a pharmacist, physician, panel of clinicians or an independent third-party utilization management company.

When and How to Request an External Review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, you must have used all internal appeal rights before requesting an external review. The external review will be conducted by an independent review organization (IRO) with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to MCMC, LLC, which is an independent third party utilization management company, at:

MCMC LLC
Attn: Express Scripts Appeal Program 300 Crown Colony Drive, Suite 203
Quincy, MA 02169-0929
Fax Number: 617.375.7683
Phone Number: 617.375.7700, ext. 28253

MCMC must receive the external review request within 4 months of the date of the final internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

External Review & Notification Process

MCMC will review a **standard** external review request within 5 business days to determine if it is eligible to be forwarded to an IRO and the patient will be notified within 1 business day of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO.

The IRO will notify the claimant in writing that it has received the request for an external review, and if the IRO has determined that the claim involves medical judgment or rescission, the letter will

describe the claimant's right to submit additional information within 10 business days for consideration to the IRO.

Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Once an **urgent** external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

CLAIMS PROCEDURES DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Claims forms for filing claims for life and accidental death and dismemberment benefits are available from the Fund Office. Claims should be filed with the Fund Office as soon as possible. The Fund Office should be notified by your named beneficiary within twenty (20) days of your death. Written proof of death (two certified copies of the death certificate) should be submitted to the Trust Office within ninety (90) days of the date of death. All claims for benefits, with sufficient supporting documentation, must be submitted to the Fund Office within 12 months from the date of death of the participant. All liability on the part of the Fund and the Trustees shall cease and any person's claim for benefits shall be forfeited unless a claim and the required proofs are submitted to the Fund Office within 12 months from the date of death

INITIAL CLAIMS DETERMINATIONS

If your claim is based on death or dismemberment

The Fund or Board of Trustees will make a determination on the claim within a reasonable period of time, but no longer than 90 days after the claim is received unless special circumstances require extra time for processing. If such a time extension is necessary, you will receive written notice before the end of the initial 90 days.
This notice will tell you why additional time is needed and the date you can expect a final decision. This decision must be made within 90 days after the end of the initial 90-day period.

If your claim is based on disability (waiver of premium)

If your claim involves a determination as to whether you are disabled, the Fund or Board of Trustees will make a determination on your claim within a reasonable period of time, but not later than 45 days after a claim is received. This time period may be extended for an additional 60 days, in the form of two 30-day extensions, when necessary due to matters beyond the control of the insurance. You will be advised in writing of the need for an extension during the initial 45-day period and you

will be notified of the need for a second extension of time before the end of the first extension period. The notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and any additional information needed to resolve those issues.

If the extension is needed because you failed to submit information necessary to decide the claim, the notice will specifically describe the needed information and you will be allowed 45 days from receipt of the notice to provide the additional information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you provide the requested information within the specified timeframe, your claim will be decided within the time specified in the extension notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.
If either type of claim is denied in whole or in part, you or your beneficiary will receive a written notice that includes:

- The specific reason for the denial.
- A specific reference to the plan provisions on which the denial is based.
- A description of any additional material or information necessary for you to substantiate your claim and an explanation of why such material is needed.
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
  - Your right to submit written comments and have them considered,
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and
  - Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal.

REVIEW OF DENIED CLAIMS

You may appeal the denial of your claim to the Fund or Board of Trustees. If your claim involves death or dismemberment, this appeal must be made in writing within 60 days after you receive the written notice from the insurance company that your claim had been denied in whole or in part. If you do not file your appeal within this time period, you will lose the right to appeal the denial. If your claim involves a determination of disability (waiver of premium), this appeal must be made in writing no more than 180 days after you receive the written notice from the Fund or Board of Trustees.

Your written appeal should set out the reasons you believe that the claim should not have been denied and should also include any additional supporting information, documents or comments that you consider appropriate. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

IF YOUR CLAIM IS BASED ON DEATH OR DISMEMBERMENT

The Fund or Board of Trustees will review and decide your appeal within a reasonable period of time but no longer than 60 days after it is submitted. This time period may be extended for an additional 60 days if the Fund or Board of Trustees determines that there are special circumstances that require an extension. You will be advised in writing of the need for an extension during the

initial 60-day period and a determination will be made no more than 120 days after the date the claim was submitted. If the extension is needed because you failed to submit information necessary to decide the claim, the period for deciding the appeal shall be tolled from the date on which the Fund or Board of Trustees sends you notification of the extension until the date on which you respond to the request for additional information.

IF YOUR CLAIM IS BASED ON DISABILITY

The Fund or Board of Trustees will review and decide your appeal within a reasonable period of time but no longer than 45 days after it is submitted. This time period may be extended for an additional 60 days if the Fund or Board of Trustees determines that there are special circumstances that require an extension. You will be advised in writing of the need for an extension during the initial 60-day period and a determination will be made no more than 120 days after the date the claim was submitted. If the extension is needed because you failed to submit information necessary to decide the claim, the period for deciding the appeal shall be tolled from the date on which the Fund or Board of Trustees sends you notification of the extension until the date on which you respond to the request for additional information.

The review of each type of appeal will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. The review will not give deference to the initial. In addition, the individual who decides your appeal will not be the same individual who initially decided your claim and will not be that individual's subordinate.

The Fund or Board of Trustees may consult with a health professional in deciding your appeal, except that any health professional consulted in connection with your appeal will not have been involved in the initial benefit determination nor be a subordinate of the health professional who was involved.
You will be notified in writing if the decision on appeal upholds the initial denial of your claim. The notification will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- A statement of your right to bring a civil action under Section 502 of ERISA.

The decision of the Fund or Board of Trustees is final and binding on all individuals dealing with or claiming benefits under the plan.

DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. This authorization must be in writing and signed by you. Any reference in these claims procedures to "you" is intended to include your authorized representative.

FRAUDULENT CLAIMS

If a fraudulent claim is knowingly submitted, all benefits claimed will be denied. If any benefits are paid in connection with a fraudulent claim, the Participant and his dependents will not receive further benefits under the Fund until the money improperly obtained is returned to the Fund. The Participant will be advised by mail of any action taken with regard to a fraudulent claim.

TRUSTEES' DISCRETION AND AUTHORITY TO RENDER FINAL AND BINDING DECISIONS

The decision of the Board of Trustees on review/appeal shall be final and binding upon all parties including any person claiming a benefit on your behalf. There is no further appeal under this Plan. Under special circumstances, the Trustees may determine that reconsideration of your claim or appeal is appropriate based on new information that was not available at the time of the initial appeal. The Trustees have full authority and discretion to determine if reconsideration is warranted.

The Trustees have full discretion or authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility and interpretation of the plan and other Fund policies and rules. The Trustees shall have full authority and discretion to determine if a benefit is covered or subject to reimbursement under the Plan. If the Trustees deny your appeal of a claim, and you decide to seek judicial review, the Trustees' decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

REVIEW OF FUND POLICIES, DETERMINATIONS, OR ACTIONS NOT INVOLVING CLAIMS FOR BENEFITS

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

You may review pertinent documents in the Fund Office after making appropriate arrangements or you may request that documents be provided to you. The Fund may charge you $.25 per page to provide documents to you, and this amount must be paid in advance.

The Trustees or a designated Committee of the Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Fund Office within 30 days of the date of the meeting. In this case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal.

You may wish to contact the Fund Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require an extension of the time for review for the Trustees or Committee, you will be notified in writing.

REIMBURSEMENT AND SUBROGATION

THE PLAN'S REIMBURSEMENT RIGHTS

If you or another covered person receives any benefits arising out of an injury, illness or other condition for which there is or may be a claim or right of recovery against a third party, any payments under this Plan for such benefits shall be on the condition and understanding that this Plan will be reimbursed. The Plan's reimbursement provisions apply when you or another covered person (which shall be understood to include your estate) receives any amounts by settlement, judgment, verdict or otherwise, including payment under an insurance policy, for an injury, illness or other condition caused by a third party, or for an on the job injury, illness or other condition covered by workers' compensation. Examples are if you are injured in an automobile accident and the other driver is at fault, or if you are injured on the job and receive a workers' compensation recovery.

The amounts that you receive on account of the liability of a third party or the employer, or on account of a workers' compensation recovery are referred to here as a "recovery". If you or another covered person (or your estate) receives a recovery, the Plan will subtract the amount of the recovery from the benefits it would otherwise pay arising out of that injury, illness or other condition, including for treatment, disability income payments for lost wages, accidental death or dismemberment benefits or otherwise.

If the Plan has already paid benefits arising out of the injury, illness or other condition, such payment will be considered to be an "advance" only and you or the covered person (or your estate) must promptly reimburse the Plan from any recovery received for the amount of benefits so advanced by the Plan.

Reimbursement must be made regardless of whether the covered person is fully compensated ("made whole") by the recovery and regardless of whether or not such proceeds are characterized in the settlement or judgment as being paid on account of the expenses, condition or losses for which benefits were paid, and without any reduction for any legal or other expenses incurred by any covered person in connection with the recovery against the third party, that third party's insurer, the employer or a workers' compensation insurer, except as may be expressly agreed to by the Plan at its sole discretion. By accepting the advance of benefits from the Plan, all covered persons are deemed to agree to this repayment provision.
Covered persons may be required to execute an agreement under which they jointly and severally:

- Grant the Plan a first priority lien against the proceeds of any recovery received;
- Assign to the Plan any benefit they may have under any insurance policy or other coverage, and
- Agree to hold the proceeds of any recovery received in trust for the plan.

Payments of future benefits under the Plan may be conditioned on execution of this agreement by covered persons and by any legal counsel they retain in pursuing a recovery.
Each covered person is obligated to cooperate with the Plan and its agents in order to protect the Plan's reimbursement rights. Cooperation means promptly signing, and having your legal counsel sign and deliver any subrogation and reimbursement agreement, providing the Plan or its agents with any relevant information requested, signing and delivering any documents as the Plan or its agents reasonably request, keeping the Plan fully informed as to the status of any litigation or settlement efforts in pursuing a recovery, obtaining the written consent of the Plan or its agents before accepting a settlement offer or recovery or releasing any party from liability, taking actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery and taking no action that may prejudice the Plan's rights. Failure to cooperate may be grounds for the termination of all future benefits under the Plan.

The Plan is only responsible for those legal costs to which it agrees in writing and will not otherwise bear the legal costs of covered persons.

If you or any person whom you cover under the Plan fails to reimburse the Plan as required by this section, the Plan may apply any future benefits that may become payable to you or your family members to the amount not reimbursed. Alternatively, the Plan may enforce its rights through garnishment, attachment of wages, liens on assets or any other legal or equitable means.

FUTURE MEDICAL EXPENSES, LOSSES OR CONDITIONS

A recovery may include compensation for injury-related medical expenses or other injury-related losses or conditions that a covered person may incur in the future. If the settlement or judgment does not set out the amount of the recovery allocated for future medical expenses, losses or conditions, you and the Fund will attempt to agree on the amount.

If there is no agreement, the amount attributable to future medical expenses, losses or conditions will be determined by the Fund in its sole and absolute authority.

The Plan will not cover future medical expenses, losses or conditions for which a covered person is being compensated. Expenses, losses or conditions that are compensated by the recovery will not be covered or applied to the deductible or co-payment requirements of the Plan until they exceed the amount that the covered person has received, or is entitled to receive, as compensation for future medical expenses, losses or conditions.

In some instances, the third party may compensate the covered person for both past and future medical expenses, losses or conditions through an insurance policy. In that event, only expenses, losses or conditions that are not paid by the insurance policy will be eligible for reimbursement by this Plan.

THE PLAN'S SUBROGATION RIGHTS

The Plan's subrogation provisions apply when another party or the employer (including an insurance carrier or workers' compensation carrier) is or may be liable for a covered person's injury, illness, losses or other condition and the Plan has already paid benefits arising out of the injury, illness, losses or other condition. "Subrogation" refers to the right of the Plan to be substituted in place of the covered person with respect to that person's lawful claim, demand, or right of action against a person who may have wrongfully caused, or is otherwise liable for the covered person's injury, illness, losses or condition that resulted in the payment of benefits by the Plan.

In exercising its subrogation rights, the Plan at its discretion may start any legal action or administrative proceeding it deems necessary to protect its right to recover any amount it has advanced as benefits and it may try or settle any such action or proceeding in the name of and with the full cooperation of the covered persons. However in doing so, the Plan will not represent or provide legal representation for any covered person with respect to that covered person's damages to the extent those damages exceed the amount of plan benefits.

In addition, the Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any covered person against any person or employer or that person's or employer's insurer on account of any alleged negligent, intentional, or otherwise wrongful action, or on account of a work related injury covered by workers' compensation law, that may have caused or contributed to the covered person's injury, illness, losses or condition that resulted in the payment of benefits by the Plan.

Each covered person is obligated to cooperate with the Plan and its agents in order to protect the plan's subrogation rights.

Cooperation means providing the Plan or its agents with any relevant information requested, promptly signing, and having your legal counsel sign and deliver any subrogation and reimbursement agreement, signing and delivering any documents as the Plan or its agents reasonably request, keeping the plan fully informed as to the status of any litigation or settlement efforts in pursuing a recovery, obtaining the written consent of the Plan or its agents before accepting any settlement offer or recovery or releasing any party from liability, taking actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery and taking no action that may prejudice the Plan's rights.

Failure to cooperate or taking actions that prejudice the Plan's subrogation rights may be grounds for the termination of all future benefits under the Plan.

The Plan's legal costs in subrogation matters will be borne by the Plan. The legal costs of covered persons will be borne by such covered persons.

GENERAL INFORMATION AND YOUR ERISA RIGHTS

ADMINISTRATIVE INFORMATION

This Plan is maintained pursuant to Collective Bargaining Agreements and contributions to the Plan are made by contributing employers and by Participants under certain circumstances.

Plan name and Address: IUPAT District Council No. 51 Health Fund
c/o Zenith American Solutions
Three Gateway Center
401 Liberty Avenue, Suite 1200

Pittsburgh, PA 15222
(412) 471-2885 or toll free (800) 242-8923

Fund Identification Number: 52-5034933

Plan Number: 501

Type of Plan: This is an employee welfare benefit plan that provides medical, prescription drug, dental, vision, death, accidental death and dismemberment and disability benefits.

Administration: The Plan is provided through and administered by the Joint Board of Trustees of IUPAT District Council No. 51 Health Fund, Three Gateway Center, 401 Liberty Ave., Ste. 1200, Pittsburgh, PA 15222. The Joint Board of Trustees has engaged the services of Zenith American Solutions as the Contract Administrator to handle the day-to-day administration of the Plan.

Agent for Service of Legal Process: Any one of the Trustees may be served at his address listed below or service may be made on the Contract Administrator at the Fund Office.

Name, title and address of the principal place of business of the Trustees:

UNION TRUSTEES

Lynn Taylor
IUPAT District Council No. 51
4700 Boston Way
Lanham, MD 20706

Charles Parker
IUPAT District Council No. 51
4700 Boston Way
Lanham, MD 20706

Derwin Scalph, Jr.
IUPAT District Council No. 51
4700 Boston Way
Lanham, MD 20706

Manuel Rauda
IUPAT District Council No. 51
4700 Boston Way
Lanham, MD 20706

EMPLOYER TRUSTEES

Tom Kousisis
Alpha Painting & Construction Co. Inc.
6800 Quad Avenue
Baltimore, MD 21237

Funding Medium: Benefits are self-funded and provided from the Fund's assets, which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in the Trust Fund for the purpose of providing benefits to covered Participants and paying reasonable administrative expenses.

The Fund has liability for all benefits and determines benefit payments in accordance with rules promulgated by the Board of Trustees.

Contribution Source: All contributions to the Plan are made by Employers in accordance with collective bargaining agreements between the Union and the Employers. These agreements provide that Employers contribute to the Fund on behalf of each covered employee on the basis of a fixed rate.
The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Fund on behalf of Participants working under the collective bargaining agreement.

Plan Termination: The Trustees intend to continue the Plan described in this booklet indefinitely. Nevertheless, they reserve the right, subject to the provisions of pertinent collective bargaining agreements, to amend, modify or terminate the Plan.

If the Plan terminates, the Trustees will apply the remaining assets of the Fund to continue benefits beyond the date of termination. The Trustees reserve the right to amend the eligibility rules at the time of termination. Retiree benefits are funded from current contributions and are not vested nor

guaranteed. The Trustees will use remaining assets of the Fund to provide benefits, pay administration expenses and otherwise to carry out the purposes of the Plan in an equitable manner until the entire remainder of the Fund has been disbursed.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Participant in the IUPAT District Council No. 51 Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all Plan documents, including detailed annual reports and Plan descriptions and all documents filed by the Plan with the U.S. Department of Labor. Make arrangements to see the documents by calling or writing the Administrator at the Fund Office.

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE

In addition, if you are a participant in a group health plan, you have the right to:

- 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 will have to pay for such coverage. Review this summary plan description and the documents governing the plan for information regarding your COBRA continuation coverage rights.

- A reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable 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 subject to a pre-existing condition exclusion or limitation, as described in the summary plan description. Note that this right is available only if you are a participant in a group health plan that is subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plans, called "plan fiduciaries," have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, 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.

ENFORCE YOUR RIGHTS

If your claim for a benefit is denied or ignored, in whole or in part, you have the 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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 (formerly the Pension and Welfare Benefits 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, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A

Preventive Services: The Plan will pay 100% of the negotiated, discounted rate payable by Care First/BlueCross BlueShield for the Preventive Services listed below when provided by a network Provider. If your Provider does not bill a preventive service separately from an office visit, and the primary purpose of the visit is the delivery of the preventive service, you will not be charged a deductible or co-payment for the office visit. If, however, the preventive service is not billed separately from an office visit and the preventive service is not the primary purpose of the visit, you will be charged for the office visit.

For adults, services with an "A" or "B" recommendation from the United States Preventive Services Task Force ("USPSTF") (meaning that the USPSTF recommends the service as having a net benefit that is either substantial ("A") or moderate to substantial ("B")), as periodically revised, including:

Abdominal aortic aneurysm screening for men who have smoked

Alcohol misuse screening and counseling

Aspirin use (if prescribed) to prevent cardiovascular disease and colorectal cancer for adults 50 to 57 years with a high cardiovascular risk

Blood pressure screening

Cholesterol screening for adults of certain ages or at higher risk

Colorectal cancer screening for adults 50 to 75

Depression screening

Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese

Diet counseling for adults at higher risk for chronic disease

Falls prevention (with exercise or physical therapy and vitamin D use) for adults age 65 and over, living in a community setting

Hepatitis B screen for people at high risk

HIV screening for those age 15-65 and other ages at increased risk

Immunizations for adults, at the doses, recommended ages, and recommended populations described by the Centers for Disease Control ("CDC")'s Advisory Committee on Immunization Practices ("ACIP") for routine vaccinations, as periodically revised, including:

Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus (HPV), Influenza (Flu Shot), Measles, Mumps, Rubella (MMR), Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis (Td/Tdap), Varicella, Shingles (for adults age 60 and older – not a routine vaccination described by the CDC but covered by the Plan)

Lung cancer screening for adults 55-80 at high risk for lung cancer because they are heavy smokers or have quit in the past 15 years

Obesity screening and counseling for all adults

Sexually Transmitted Infection ("STI") prevention counseling for adults at higher risk

Statin prevention medication for adults 40 to 75 at high risk

Syphilis screening for all adults at higher risk

Tobacco use screening for all adults and cessation interventions for tobacco users

Tuberculosis screening for certain adults without symptoms at high risk

For women, preventive care and screening as recommended in guidelines supported by the Health Resources and Services Administration ("HRSA"), as periodically revised, including:

- Anemia screening on a routine basis for pregnant women
- Breast cancer genetic test counseling ("BRCA") for women at higher risk of breast cancer
- Breast cancer mammography screenings every 1 to 2 years for women over 40
- Breast cancer chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers and access to breastfeeding supplies for pregnant and nursing women
- Cervical cancer screening for sexually active women
    - Pap test every 3 years for women 21 to 65
    - HPV DNA test with a combination of a Pap smear every 5 years for women 30 to 65 who don’t want a Pap smear every 3 years
- Chlamydia infection screening for younger women and other women at higher risk
- Contraception using Food and Drug Administration ("FDA")-approved methods, sterilization procedures and patient education and counseling as prescribed by a health care provider for women with reproductive capacity
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- HIV screening and counseling for sexually active women
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually Transmitted Infections ("STI") counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Tobacco use screening and interventions and expanded counseling for pregnant tobacco users
- Urinary tract or other infection screening for pregnant women
- Well-woman visits for women under 65

For infants, children, and adolescents, preventive care and screenings as recommended in guidelines supported by HRSA, as periodically revised, including:
- Alcohol, tobacco and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments
- Bilirubin concentration screening for newborns
- Blood pressure screening
- Blood screening for newborns
- Cervical dysplasia screening for sexually active females
- Depression screening for adolescents
- Developmental screening for children under age 3
- Dyslipidemia screening for children at higher risk of lipid disorders
- Fluoride chemoprevention supplements for children without fluoride in their water sources
- Fluoride varnish for all infants and children as soon as teeth are present
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns, and for children once between 11 and 14 years, once between 15 and 17 years and once between 18 and 21 years
- Height, weight and body mass index measurements
- Hematocrit or hemoglobin screening
- Hemoglobinpathies or sickle cell screening for newborns
- Hepatitis B screen for adolescents at higher risk
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- Immunization vaccines at the doses, recommended ages, and recommended populations described by the Centers for Disease Control ("CDC")'s Advisory Committee on Immunization Practices ("ACIP") for routine vaccinations, as periodically revised, including:
  - Diphtheria, Tetanus, Pertussis ("Dtp/Dtap")
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus ("HPV")
  - Inactivated poliovirus
  - Influenza ("Flu shot")
  - Measles, Mumps, Rubella ("MMR")
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella

Iron supplements for children ages 6 to 12 months at risk for anemia
Lead screening for children at risk of exposure
Maternal depression screening for mothers of infants
Medical history
Obesity screening and counseling
Oral health risk assessment for children up to 10 years old Phenylketonuria ("PKU") screening in newborns
Sexually Transmitted Infection ("STI") prevention counseling and screening for adolescents at higher risk
Tuberculin testing for children at higher risk of tuberculosis
Vision screening