UNITED WORKERS HEALTH FUND
COMPREHENSIVE HEALTH PLAN

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
PLAN C

Effective: August 1, 2014
Restated: September 1, 2015

Third Party Administrator:
Dickinson Group, LLC.
50 Charles Lindbergh Blvd., Suite 207
Uniondale, NY 11553

TABLE OF CONTENTS

ESTABLISHMENT OF THE *PLAN*

THIS *PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION* (the "*summary plan description*"), made by The United Workers Health Fund (the "*Company*" or the "*Plan Sponsor*") effective August 1, 2014.

What is the effective date of the *Plan*?
The *summary plan description* is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the employees covered by such agreement.

Adoption of the *summary plan description*
The *Plan Sponsor*, as the settlor of the *Plan*, hereby adopts this *summary plan description* as the written description of the *Plan*. This *summary plan description* represents both the *plan document* and the *summary plan description*, which is required by *ERISA*. This *summary plan description* amends and replaces any prior statement of the health care coverage contained in the *Plan* or any predecessor to the *Plan*.

This *Plan* is maintained pursuant to an agreement between the *Plan Sponsor* and United Workers of America, designated as the "*union*." A copy of the agreement between the *Plan Sponsor* and the *union* may be obtained upon written request to the *Plan Administrator* and is available for examination at the *Plan Sponsor's* principal office, and at each establishment of the *Plan Sponsor* in which at least 50 *employees* are customarily working. In the case of *employees* who do not usually work at, or report to, a single establishment of the *Plan Sponsor*, a copy of the agreement is available for examination at the meeting hall or office of said *union* in which there are at least 50 *employees*.

The association, committee, joint board of trustees, parent or most significant employer of a group of employers, all of which contribute to the *Plan*, or other similar representative of the parties who established or maintain the *Plan*, is the Board of Trustees of the United Workers Health Fund. *Participants* may receive from the *Plan Administrator*, upon written request, information as to whether a particular employer or employee organization is a sponsor of the *Plan*, and if so, the sponsor's address.

IN WITNESS WHEREOF, the *Plan Sponsor* has caused this *summary plan description* to be executed.

Board of Trustees
United Workers Health Fund
Comprehensive Health Plan

By: _____

Name: _____

Date: _____

Title: _____

Record of Plan Amendments

Amendment Number	Amendment Date	Subject of Amendment

GENERAL *PLAN* INFORMATION

What is the purpose of the *Plan*?
The *Plan Sponsor* has established the *Plan* for your benefit, on the terms and conditions described herein. The *Plan Sponsor's* purpose in establishing the *Plan* is to help to offset, for you, the economic effects arising from an *injury* or *illness*. To accomplish this purpose, the *Plan Sponsor* must be cognizant of the necessity of containing health care costs through effective plan design, and the *Plan Administrator* must abide by the terms of the *summary plan description*, to allow the *Plan Sponsor* to allocate the resources available to help those individuals participating in the *Plan* to the maximum feasible extent.

The *Plan* is not a contract of employment between you and your *participating employer* and does not give you the right to be retained in the service of your *participating employer*.

The purpose of this *summary plan description* is to set forth the terms and provisions of the *Plan* that provide for the payment or reimbursement of all or a portion of certain medical expenses. The *summary plan description* is maintained by the *Plan Administrator* and may be inspected at any time during normal working hours by any *participant*.

General *Plan* Information You Should Know

Name of *Plan*:	**The United Workers Health Fund Comprehensive Health Plan**
***Plan Sponsor*:**	**Board of Trustees of the United Workers Health Fund Comprehensive Health Plan** **50 Charles Lindbergh Blvd., Suite 207** **Uniondale, NY 11553** **(877) 347-7225**
***Plan Administrator*:** **(Named Fiduciary)**	**Board of Trustees of the United Workers Health Fund Comprehensive Health Plan** **50 Charles Lindbergh Blvd., Suite 207** **Uniondale, NY 11553** **(877) 347-7225**
***Plan Sponsor* ID No. (EIN):**	**84-1655234**
***Plan Year*:**	**January 1 through December 31**
***Plan* Number:**	**501**
***Plan* Type:**	**Medical** **Vision** **Prescription Drug**
Third Party Administrator:	**Dickinson Group, LLC.** **50 Charles Lindbergh Blvd., Suite 207** **Uniondale, NY 11553** **(877) 347-7225**
Participating Employer(s):	**The Plan is maintained pursuant to collective bargaining or participation agreements with participating Employers. A complete list of the participating Employers and copies of their respective collective bargaining or participation agreements are available for your inspection at the Fund Office. In addition, you may obtain these documents by submitting a written request**

	to the Fund Office. Please note that, consistent with Federal law, the Plan may impose a reasonable charge for reproduction of these documents.
Agent for Service of Process:	**Board of Trustees of the United Workers Health Fund Comprehensive Health Plan** **50 Charles Lindbergh Blvd., Suite 207** **Uniondale, NY 11553** **(877) 347-7225**

The *Plan* shall take effect for each *participating employer* on the *effective date* shown on the cover, unless a different date is set forth above.

The *Plan* is a legal entity. Legal notice may be filed with, and legal process served upon, the *Plan Administrator*.

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the *Plan*?
You are eligible for coverage under the Plan if you are employed by an Employer who is required, pursuant to a collective bargaining agreement, to make contributions to the Fund on your behalf. You must enroll in the Plan before your coverage will begin. In order to enroll in the Plan, you must complete an application for enrollment and return it to the Fund Office. Your coverage under the Plan will begin on the date specified in your Employer's collective bargaining agreement

Are my *dependents* eligible to participate in the *Plan*?
Your *dependents* will become eligible for coverage on the latest of the following dates:

- The date you become eligible for coverage;
- The date coverage for *dependents* first becomes available under the *Plan*; and
- The first date upon which you acquire a *dependent*.

Please note: You must be covered under the *Plan* in order to cover any *dependents*.

Who are your eligible dependents?

If the collective bargaining agreement and/or other written agreement (pursuant to which contributions are made on your behalf to the Fund which covers your participation) allows for dependent coverage, the following family members are considered a "Eligible Dependents":

"Dependent" means one or more of the following person(s):

- An e*mployee*'s lawfully married spouse possessing a marriage license who is not legally separated or divorced from the e*mployee*. For purposes of this section, "marriage or married" means a union that is legally recognized as a marriage under the state law where such marriage was performed;
- An e*mployee*'s *child* who is less than 26 years of age; or
- The definition of "Children" includes adopted children (including a "proposed adopted child" during any waiting period prior to the finalization of the child's adoption) as well as your own children, provided they meet the requirements above, and you are legally responsible for their medical expenses. Evidence of this responsibility will be required. A newborn adopted child will be covered from the date of birth provided:

  (a) you take custody of the child upon the child's release from the hospital; and
  (b) you file a petition to adopt within 30 days after the child's birth

  However, no benefits will be provided from birth if (1) the natural parent has coverage available for the child's care; or (2) a notice revoking the adoption has been filed; or (3) one of the child's natural parents revokes his/her consent to adopt. You must notify the Welfare Fund within 30 days after the date of birth for coverage to continue beyond the 30-day period.

- An e*mployee*'s *child*, who reaches age 26, who was continuously covered prior to attaining the limiting age under the bullets above, who is mentally or physically incapable of sustaining his or her own living. Such *child* must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the *Plan* must be furnished and approved by the *Plan* within 31 days after the date the *child* attains the limiting age under the bullets above. The *Plan* may require, at reasonable intervals, subsequent proof satisfactory to

the *Plan* during the next two years after such date. After such two-year period, the *Plan* may require such proof, but not more often than once each year.

- Foster children and stepchildren are not eligible for coverage under the Plan.

"*Dependent*" does not include any person who is a member of the armed forces of any country or who is a resident of a country outside the United States.

The *Plan* reserves the right to require documentation, satisfactory to the *Plan Administrator*, which establishes a *dependent* relationship

When will we become *participants* in the plan?
Coverage will become effective at 12:01 A.M. (except for newborn *children*) on the date specified in your Employer's collective bargaining agreement, subject to the conditions of this section.

- Coverage will become effective within 30 days of the date you or your *dependents* are eligible, provided you and your *dependents* have enrolled for coverage on a form satisfactory to the *Plan Administrator* within 30 days following the date of eligibility.

- For a *dependent child who* is born after the date your coverage becomes effective you must make written application and agree to any required contributions (if applicable) during the first 30 days from the *child's* birth. Coverage for the *dependent child* will then become effective from the moment of birth.

- If you acquire a *dependent* while you are eligible for coverage for *dependents*, coverage for the newly acquired *dependent* will be effective on the first day of the month following proper notification to the Fund Office. Appropriate documentation of eligibility as a covered dependent (i.e. birth certificate, marriage certificate, etc.) must be sent to the Fund Office along with notification.

What if I do not enroll during my original eligibility period and later decide to apply for coverage?
If you and your *dependents* do not enroll for coverage when you are first eligible, you are not permitted to enroll in the *Plan* at a later time, except as set forth below in the section entitled "Special Enrollment Periods."

Are there any other exceptions for enrollment?

Special Enrollment Periods
This *Plan* provides special enrollment periods that allow you to enroll in the *Plan*, even if you declined enrollment during an initial or subsequent eligibility period.

Loss of Other Coverage
If you declined enrollment for yourself or your *dependents* (including your spouse) because of other health coverage, you may enroll for coverage for yourself and/or your *dependents* if the other health coverage is lost. You must make written application for special enrollment within 30 days of the date the other health coverage was lost. For example, if you lose your other health coverage on September 15, you must notify the *Plan Administrator* and apply for coverage by close of business on October 16.

The following conditions apply to any eligible *employee* and *dependents:*

You may enroll during this special enrollment period:

- If you are eligible for coverage under the terms of this *Plan;*

- You are not currently enrolled under the *Plan*;

- When enrollment was previously offered, you declined because of coverage under another group health plan or health insurance coverage. You must have provided a written statement that other health coverage was the reason for declining enrollment under this *Plan;* and

- If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

- A participant receiving individual coverage may elect to change to family coverage during the month of December (December 1st – December 31st) of any calendar year. Any election made thereafter will become effective on December 1st of the following year. If the change from individual to family coverage is due to marriage or the birth or adoption (including placement for adoption) of a child, the election will be permitted provided that it is done no later than 30 calendar days following the event.

You are not eligible for this special enrollment right if:

- The other coverage was *COBRA* continuation coverage and you did not exhaust the maximum time available to you for that *COBRA* coverage, or

- The other coverage was lost due to non-payment of premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for you and/or your *dependent(s)* will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the *Plan*.

New Dependent

If you acquire a new *dependent* as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your *dependents* during a special enrollment period. You must make written application for special enrollment no later than 30 days after you acquire the new *dependent*. For example, if you are married on September 15, you must notify the *Plan Administrator* and apply for coverage by close of business on October 16.

The following conditions apply to any eligible *employee* and *dependents:*

You may enroll yourself and/or your *eligible dependents* during this special enrollment period if:

- You are eligible for coverage under the terms of this *Plan*, and

- You have acquired a new *dependent* through marriage, birth, adoption or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for you and your *dependent(s)* will be effective at 12:01 A.M.:

- For a marriage, on the first day of the calendar month following enrollment.

- For a birth, on the date of birth.

- For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

Special Enrollment for Previously Enrolled *Participants*

Dependents who had ceased to be eligible to enroll in the *Plan* prior to the passage of the Patient Protection and Affordable Care Act shall be eligible to re-enroll during the special enrollment period. All *dependents* whose coverage under this *Plan* had previously ended, or who were denied coverage (or were not eligible for

coverage) because the availability of *dependent* coverage of *children* ended before age 26, are eligible to enroll, or re-enroll in the *Plan* or coverage during the special enrollment period.

Participants who were previously enrolled, but were terminated from *Plan* participation because of a prior lifetime limitation provision shall be eligible to re-enroll during the special enrollment period. All *participants* whose coverage under this *Plan* had previously ended, or who were denied coverage (or were not eligible for coverage) because the prior lifetime limitation had been reached, are eligible to enroll, or re-enroll in the *Plan* or coverage during the special enrollment period.

Additional Special Enrollment Rights

Employees and *dependents* who are eligible but not enrolled are entitled to enroll under the following circumstances:

- The *employee's* or *dependent's* Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the *employee* requests coverage under the *Plan* within 60 days after the termination; or

- The *employee* or *dependent* becomes eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the *employee* requests coverage under the *Plan* within 60 days after eligibility is determined.

What if a court orders coverage for a *child*?

Federal law requires the *Plan*, under certain circumstances, to provide coverage for your *children*. The details of these requirements are summarized below. Be sure you read them carefully

The *Plan Administrator* shall enroll for immediate coverage under this *Plan* any *alternate recipient* who is the subject of a "*medical child support order" ("MCSO")* or *"national medical support notice" ("NMSN")* that is a "*qualified medical child support order*" ("*QMCSO*") if the *child* named in the *MCSO* is not already covered by the *Plan* as an eligible *dependent*, once the *Plan Administrator* has determined that the order or notice meets the standards for qualification set forth below.

"A*lternate recipient*" shall mean any *child* of a *participant* who is recognized under a *MCSO* as having a right to enrollment under this *Plan* as the *participant's e*ligible *dependent*. *"MCSO"* shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a *participant's child* or directs the *participant* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

- Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a group health plan.

"*NMSN*" shall mean a notice that contains the following information:

- Name of an issuing state agency;

- Name and mailing address (if any) of an *employee* who is a *participant* under the *Plan*;

- Name and mailing address of one or more *alternate recipients* (i.e., the *child* or *children* of the *participant* or the name and address of a substituted official or agency that has been substituted for the mailing address of the *alternate recipients(s)*); and

- Identity of an underlying child support order.

"*QMCSO*" is an *MCSO* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *participant* or eligible *dependent* is entitled under this *Plan*. In order for such order to be a *QMCSO*, it must clearly specify the following:

- The name and last known mailing address (if any) of the *participant* and the name and mailing address of each *alternate recipient* covered by the order;
- A reasonable description of the type of coverage to be provided by the *Plan* to each *alternate recipient*, or the manner in which such type of coverage is to be determined;
- The period of coverage to which the order pertains; and
- The name of this *Plan*.

In addition, a *NMSN* shall be deemed a *QMCSO* if it:

- Contains the information set forth above in the definition of "*NMSN*";
    - Identifies either the specific type of coverage or all available group health coverage. If the employer receives a *NMSN* that does not designate either specific type(s) of coverage or all available coverage, the employer and the *Plan Administrator* will assume that all are designated; or
    - Informs the *Plan Administrator* that, if a group health plan has multiple options and the *participant* is not enrolled, the issuing agency will make a selection after the *NMSN* is qualified, and, if the agency does not respond within 20 days, the *child* will be enrolled under the *Plan's* default option (if any); and
- Specifies that the period of coverage may end for the *alternate recipient(s)* only when similarly situated *dependents* are no longer eligible for coverage under the terms of the *Plan*, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the *Plan* to provide any type or form of benefit, or any option, not otherwise provided to *participants* without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSO's, as described in Social Security Act §1908.

Upon receiving a *MCSO*, the *Plan Administrator* shall, as soon as administratively possible:

- Notify the *participant* and each *alternate recipient* covered by the order (at the address included in the order) in writing of the receipt of such order and the *Plan's* procedures for determining whether the order qualifies as a *QMCSO*; and
- Make an administrative determination if the order is a *QMCSO* and notify the *participant* and each affected *alternate recipient* of such determination.

Upon receiving a *NMSN*, the *Plan Administrator* shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the *child* is available under the terms of the *Plan* and, if so:
    - Whether the *child* is covered under the *Plan*; and
    - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the *Plan Administrator* shall:

- Establish reasonable, written procedures for determining the qualified status of a *MCSO* or *NMSN*; and

- Permit any *alternate recipient* to designate a representative for receipt of copies of the notices that are sent to the *alternate recipient* with respect to the order.

What if I was covered under a *prior plan*?
Eligible *employees* of an acquired company who are *actively at work* and who were covered under the prior health plan of the acquired company will be eligible for the benefits under this *Plan* on the date of acquisition. Any *waiting period* previously satisfied under the prior health plan will be applied toward satisfaction of the *waiting period* of this *Plan*. In the event that an acquired company did not have a prior health plan, you will be eligible on the date of the acquisition.

Changing status
When you change your coverage status between that of an *employee* and a *dependent*, and there is no break in coverage, full credit will be given for any amounts applied toward satisfaction of the current *plan year deductible* and *out-of-pocket expense* limit, and any amounts applied toward *Plan* maximums will be carried forward.

YOUR COSTS

You must pay for a certain portion of the cost of *covered expenses* under the *Plan,* including *deductibles,* copayments and the coinsurance percentage that is not paid by the *Plan.* This is called "*out-of-pocket expense."*

Deductibles and copayments are shown in the "Schedule of Benefits." The annual *deductible* applies to services rendered by a non-*PPO network provider* only.

There may be differences in the coinsurance percentage payable by the *Plan* depending upon whether you are using a *PPO network provider* or a non-*PPO network provider*. These payment levels are also shown in the "Schedule of Benefits."

Certain types of expenses may be subject to dollar maximums or limited to a certain number of visits in a given year. This information is contained in the "Schedule of Benefits" section.

The *Plan* will not reimburse any expense that is not a *covered expense.* In addition, you must pay any expenses to which you have agreed that are in excess of the Plan's allowance, and any penalties for failure to comply with requirements of the "Cost Containment Provisions" section or penalties that are otherwise stated in the *Plan*.

If you have any questions about whether an expense is a *covered expense*, please contact the *third party administrator* for assistance.

SCHEDULE OF MEDICAL BENEFITS

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in sections, "Medical Benefits" and "Exclusions and Limitations." You may find the "Definitions" section helpful in understanding some of the italicized terms used throughout this *summary plan description*. In addition, the *Plan* has other requirements and provisions that may affect benefits, such as "Cost Containment Provisions," and it is strongly recommended that you read the entire *summary plan description* to ensure a complete understanding of the *Plan* provisions. You may also contact the *third party administrator* or the *Plan Administrator* for assistance.

Overview of PPO/Non-PPO Option - Applicable to Medical Benefits Only
The *Plan Administrator* has entered into an agreement with one or more networks of *hospitals* and *physicians*, called *"PPO networks."* The PPO network for your plan is Empire Blue Cross Blue Shield. *PPO networks* offer *participants* health care services at discounted rates. Using a *PPO network provider* will normally result in a lower cost to the *Plan* as well as to the *participant.* There is no requirement for any *participant* to seek care from a *provider* who participates in the *PPO network*. The choice of *provider* is entirely up to the *participant*.

Some *PPO network provider hospitals* have arrangements through which the benefit payable is more than the actual charges, e.g., per diem or diagnosis-related group (DRG) charges. When this occurs, the *Plan* will reimburse the *hospital* based upon the agreed per diem or DRG rates. A current list of *PPO network providers* is available, without charge, through the *third party administrator* or through the website located at www.anthem.com.

Each *participant* has a free choice of any *physician* or surgeon, and the *physician*-patient relationship shall be maintained. The *participant*, together with his or her *physician*, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the *Plan* will pay for all or a portion of the cost of such care. The *PPO providers* are merely independent contractors; neither the *Plan* nor the *Plan Administrator* make any warranty as to the quality of care that may be rendered by any *PPO provider*.

Many *PPO network providers* will require that the *Plan* offer incentives, or "steerage," in order to encourage *participants* to use their member *providers*. This *Plan* defines "steerage" as lower costs to the *participant* through reduced charges, resulting in lower out-of-pocket amounts, or higher rates of reimbursement under the *Plan*. The *Plan Administrator* reserves the right to negotiate discounts with *providers* of service, and those discounts will be used to reduce the amount of otherwise *covered expenses* considered for payment by the *Plan*. In certain cases, the *Plan Administrator*, in its sole discretion, may determine that the benefit payable for a discounted claim will be at the *PPO network provider* reimbursement level, and such payments will be considered to be in full compliance with the terms of the *Plan*.

This Plan does not provide coverage for services rendered by a non-participating provider, except for Emergency services which includes Emergency Room treatment and Ambulance.

Deductibles, Percentage Payable and Out-of-Pocket Expense Limits
The following amounts are applied per *participant* per *plan year*:

	PPO Network Providers	**Non-*PPO Network Providers***
Deductible • Individual	$0	$0
Out of Pocket Limit	$6,350 Individual $12,700 Family	No limit
Percentage Payable (unless otherwise stated)	100%	No Coverage except for required Emergency Care
* Certain types of expenses are not accumulated toward this *out-of-pocket expense* limit. These expenses are identified in the section, "Your Costs."		

Payment Levels and Limits
Maximums stated apply to the amount of benefit payments unless otherwise indicated.

***Hospital Inpatient* Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Medical/Surgical Room & Board & Ancillary	30% of *PPO* rate to a maximum copayment of $3,000; then 100% of *PPO* rate for semi-private room and ancillary charges	Not Covered	Pre-Certification Required
Intensive Care Unit Room & Board	30% of *PPO* rate to a maximum copayment of $3,000; then 100% of *PPO* rate for Intensive Care Unit and ancillary charges	Not Covered	Pre-Certification Required
Personal Items	Not Covered	Not Covered	
Extended Skilled Nursing Facility, Room & Board & Ancillary	30% of *PPO* rate to a maximum copayment of $3,000; then 100% of *PPO* rate	Not Covered	Pre-Certification Required
Rehabilitation Facility Room & Board & Ancillary	30% of *PPO* rate to a maximum copayment of $3,000; then 100% of *PPO* rate	Not Covered	*Confinement must follow a prior admission to a hospital and must be for continued treatment.* Pre-Certification Required

***Hospital* Newborn Care**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Neo-Natal Room & Board & Ancillary	30% of *PPO* rate to a maximum copayment of $3,000; then 100% of *PPO* rate	Not Covered	Pre-Certification Required
Newborn Nursery & Ancillary	30% of *PPO* rate to a maximum copayment of $3,000; then 100% of *PPO* rate	Not Covered	

***Physician* In-*Hospital* Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Physician Medical *Hospital* Visit	$50 copayment 100% of *PPO* rate	Not Covered	
Physician Newborn Visit	$50 copayment 100% of *PPO* rate	Not Covered	
Consultant Visit	$50 copayment 100% of *PPO* rate	Not Covered	

Surgical *Inpatient* Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Anesthesia	30% of *PPO* rate to a maximum copayment of $1,500; then 100% of *PPO* rate	Not Covered	
Assistant Surgeon	$250 copayment 100% of *PPO* rate	Not Covered	
Obstetrical	$250 copayment 100% of *PPO* rate	Not Covered	
Surgeon	$250 copayment 100% of *PPO* rate	Not Covered	Pre-Certification Required

Surgical Outpatient Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Anesthesia	30% of *PPO* rate to a maximum copayment of $1,500; then 100% of *PPO* rate	Not Covered	
Assistant Surgeon	$250 copayment 100% of *PPO* rate	Not Covered	
Obstetrical	$250 copayment 100% of *PPO* rate	Not Covered	
Surgeon	$250 copayment 100% of *PPO* rate	Not Covered	Pre-Certification Required

Professional Interpretation Services *Inpatient* and Outpatient			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Pathologist Fee	$20 copayment; 100% of *PPO* rate	Not Covered	
Radiologist Fee	$20 copayment; 100% of *PPO* rate	Not Covered	

***Hospital Emergency* Room Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Emergency Room - Accident & Illness	$150 copayment 100% of *PPO* rate	100% of *usual, customary and reasonable fees*	Co-payment waived if admitted
Emergency Room Physician – Accident & Illness	$50 copayment 100% of *PPO* rate	100% of *usual, customary and reasonable fees*	
Emergency Room – Non-Emergency Conditions	Not Covered	Not Covered	
Urgent Care (other than Emergency Room)	$50 copayment 100% PPO rate	100% of *usual, customary and reasonable fees*	

Outpatient *Diagnostic Services*			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Diagnostic Laboratory	$20 copayment 100% of *PPO* rate	Not Covered	
Diagnostic X-ray	$20 copayment 100% of *PPO* rate	Not Covered	
Imaging (SPECT/PET,MRI, etc)	$250 copayment 100% of PPO rate	Not Covered	Pre-Certification Required
Cat Scan	$100 copayment 100% of PPO rate	Not Covered	Pre-Certification Required
Pre-Admission Testing Within 7 days of admission	$20 copayment 100% of *PPO* rate	Not Covered	

Outpatient Facility Fees			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Ambulatory Surgery Center	30% of *PPO* rate to a maximum copayment of $3,000; then 100% of *PPO* rate	Not Covered	Pre-Certification Required

Outpatient Therapy Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Occupational Therapy & Speech Therapy	$50 copayment 100% of *PPO* rate	Not Covered	20 visit limit per calendar year for these therapies combined
Chemotherapy	50% of PPO rate	Not Covered	Pre-Certification Required

Outpatient Therapy Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Dialysis	50% of PPO rate	Not Covered	Pre-Certification Required
Physical Therapy	$50 copayment 100% of *PPO* rate	Not Covered	Limited to 20 visits per *calendar year*
Radiation Therapy	$50 copayment 100% of *PPO* rate	Not Covered	Pre-Certification Required

Physician's Office Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Office Visit	$30 copayment 100% of *PPO* rate	Not Covered	
Specialist Visit	$50 copayment 100% PPO rate	Not Covered	
Diagnostic X-ray	$20 copayment 100% of *PPO* rate	Not Covered	
Diagnostic Laboratory	$20 copayment 100% of *PPO* rate	Not Covered	

Chiropractic Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Chiropractic Visit and Therapies	$50 copayment 100% of *PPO* rate	Not Covered	Limited to 24 visits per *calendar year*
Chiropractic X-ray	Not Covered	Not Covered	

Preventive Care Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Gynecology Exam	100% of *PPO* rate	Not Covered	1 exam per *calendar year*
Immunization	100% of *PPO* rate	Not Covered	
Mammogram	100% of *PPO* rate	Not Covered	1 exam per *calendar year*
Pap Test	100% of *PPO* rate	Not Covered	1 exam per *calendar year*
Preventive Lab Screening	100% of *PPO* rate	Not Covered	1 exam per calendar year
General Medical Examination	100% of *PPO* rate	Not Covered	1 exam per *calendar year*
Hearing Examination	Not Covered	Not Covered	
Preventive X-ray Screening	100% of *PPO* rate	Not Covered	
Prostate Examination	100% of *PPO* rate	Not Covered	
Well *Child* Care (for *children* up to age 19)	100% of *PPO* rate	Not Covered	1 exam per *calendar year*

Other *Covered Expenses*			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Ambulance — Air Transportation	100% of *PPO* rate	100% of *usual, customary and reasonable fees*	
Ambulance — Ground Transportation	100% of *PPO* rate	100% of *usual, customary and reasonable fees*	
Home Health Services	$30 copayment 100% of *PPO* rate	Not Covered	Pre-Certification Required. Must follow a prior hospital confinement.
Hospice	30% of *PPO* rate to a maximum copayment of $3,000; then 100% of *PPO* rate	Not Covered	Pre-Certification Required. Limited to 90 days *per Lifetime*.
Private Duty Nursing	Not Covered	Not Covered	
Durable Medical Equipment	50% of PPO rate	Not Covered	
Other Covered Expenses	100% of PPO rate after copayment	Not Covered	

MEDICAL COVERED EXPENSES

Please refer to the "Cost Containment Provisions" section for important information concerning any requirements of the *Plan* for prior approval of certain services. The following *covered expenses* must be *incurred* while coverage is in force under this *Plan*. Reimbursement will be made according to the "Schedule of Benefits," and will be subject to all *Plan* maximums, limitations, exclusions and other provisions.

Hospital Inpatient Benefits

***Inpatient* Care**

For medical or *surgical* care of an *illness* or *injury*, the *Plan* will reimburse *covered expenses* for semi-private *room and board* and necessary ancillary expenses. If the *hospital* does not have semi-private accommodations, the *Plan* will allow coverage for an amount equal to 90% of the private room rate.

Covered expenses will include *cardiac care units* and *intensive care units*, when appropriate for the *participant's illness or injury.*

Maternity Care

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not 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). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or *surgical* care of an *illness*, shown in the "Schedule of Benefits" and this section, and subject to the same maximums.

Newborn Care

Coverage for a newborn *child* will be available only if you have satisfied the requirements for coverage in the "Eligibility for Participation" section.

Covered expenses for newborn *children* include nursery and neo-natal intensive care *room and board*, necessary ancillary expenses, and routine newborn care during the period of *hospital* confinement, including circumcision.

Well Newborn Nursery/*Physician* Care

- **Charges for Routine Nursery Care**. Routine well newborn nursery care is *room and board*, and other normal care for which a *hospital* makes a charge.

  This coverage is only provided if a parent is a covered *employee* or covered spouse who was covered under the *Plan* at the time of the birth and the newborn *child* is an eligible *dependent* and is neither *injured* nor *ill*.

  The benefit is limited to nursery care for the newborn *child* while *hospital* confined as a result of the *child's* birth.

- **Charges for Routine Physician Care**. The benefit is limited to *fees* made by a *physician* for the first pediatric visit to the newborn *child* after birth while *hospital* confined.

  Charges for covered routine *physician* care will be applied toward the *plan* of the newborn *child*.

Skilled Nursing (or Extended Care) Facilities Benefits
Covered expenses for *inpatient skilled nursing* or (extended care) *facilities* include semi-private *room and board* accommodations, and necessary ancillary charges.

Rehabilitation Facilities Benefits
Covered expenses for *inpatient rehabilitation facilities* include semi-private *room and board* accommodations and necessary ancillary charges. The confinement must begin following an *inpatient* stay in a *hospital* and must be for continued treatment of the *illness* or *injury* being treated in the *hospital*.

Physicians' In-Hospital Services

In-*Hospital* Medical Services
Covered expenses include professional services rendered by the attending *physician* while the *participant* is *hospitalized*.

In-*Hospital* Concurrent Medical Care
Covered expenses include services rendered concurrently by a *physician* other than the attending *physician* when the *participant* is being treated for multiple, unrelated *illnesses* or *injuries*, or which require the skills of a *physician* specialist.

In-Hospital Consultant Services
Covered expenses include the services of a *physician* consultant when required for the diagnosis or treatment of *an illness* or *injury*.

Surgical Inpatient and Outpatient Services

Anesthesia Services
Covered expenses include the administration of spinal, rectal or local anesthesia, or a *drug* or other anesthetic agent by injection or inhalation, rendered by a licensed *provider*. Benefits are also payable for these services when rendered by a Certified Registered Nurse Anesthetist (CRNA). Covered expenses do not include anesthesia administered by the surgeon *physician*.

***Surgical* Assistants**
Covered expenses include services by a licensed *physician* who actively assists the operating surgeon in the performance of *surgical procedures* when the condition of the patient and complexity of the *surgery* warrant such assistance. Benefits are also provided for these services when rendered by a licensed *surgical physician's* assistant. Coverage will be provided for these services only when rendered on an *inpatient* basis, and only when the *hospital* does not employ interns and residents qualified to perform the service.

Obstetrical Services
Covered expenses include obstetrical services rendered by the *physician* in charge of the case, including services customarily rendered as prenatal and postnatal care. Benefits for obstetrical care will be based upon the *Plan* provisions in effect on the date the services are rendered.

***Surgical* Services**
Covered expenses include *surgical procedures*, including treatment for fractures and dislocations and routine pre- and post-operative care.

When more than one *surgical procedure* is performed during the same operative session, the allowed expense is calculated as follows:

- 100% of the *covered expense*, after any *PPO network provider* discount, for the most complex procedure.
- 50% of the *covered expense*, after any *PPO network provider* discount, for the second procedure.

- 25% of the *covered expense* for each subsequent procedure.

- No benefit is payable for incidental procedures (such as an appendectomy during abdominal *surgery).*

Professional Interpretation Services Inpatient and Outpatient
Covered expenses include interpretation and reporting by a licensed radiologist or pathologist for covered diagnostic tests. Benefits are provided only for testing required for the diagnosis or treatment of an *illness* or *injury*, unless otherwise provided under "Preventive Care."

Hospital Emergency Room Services
Covered expenses include:

- *Emergency* treatment of an *accidental injury*.

- *Emergency* treatment of an *illness.*

- *Covered expenses* also include *physician's* charges, and charges for radiology and pathology, for *emergency surgical* or medical care rendered in the *hospital* emergency room.

Charges for services provided at an Emergency Room resulting from an injury or illness that is determined to be a non-emergency are not covered under the Plan.

Outpatient Facility Fees
Covered expenses include the following services when provided in an outpatient department of a *hospital* or other *institution*:

Outpatient Diagnostic Examinations
Benefits are provided for services such as X-ray and laboratory examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), basal metabolism tests, and electroencephalograms (EEG), when the study is directed toward the diagnosis of an *illness* or *injury*.

Pre-Admission Testing
Benefits are provided for *pre-admission testing* for expenses *incurred* within 7 days prior to the scheduled *hospital* admission, and only when the testing is not duplicated on admission.

Outpatient *Surgery*/*Ambulatory Surgery Center*
Benefits are provided for charges by a *hospital*, *ambulatory surgical center*, or in a *physician's* office, for services required for a *surgical procedure*. The facility fees may include both services and supplies required for the *surgery*.

Chemotherapy Services
Benefits are provided for administration of chemotherapy treatment, including *drugs* and supplies used during the treatment.

Dialysis
Benefits are provided for kidney dialysis treatment, including the *fee* for *drugs* and supplies used during the treatment.

Occupational Therapy
Benefits are provided for occupational therapy to restore a *participant* to health, or to social or economic independence. These services must be performed by a licensed occupational therapist, who evaluates the performance skills of well and disabled persons of all ages, and who plans and implements programs designed to restore, develop, and maintain the *participant's* ability to accomplish satisfactorily normal daily tasks.

Occupational therapy must be ordered by the attending *physician* as part of a treatment plan that is appropriate for the *participant's illness* or *injury*.

Physical Therapy
Benefits are provided for rehabilitation concerned with restoration of function and prevention of disability following *illness*, *injury* or loss of a body part. The services must be performed by a licensed physical therapist as part of a treatment program which is appropriate for the *illness* or *injury*, and which is ordered by the attending *physician*.

Radiation Therapy
Benefits are provided for treatment by X-ray, radium, external radiation, or radioactive isotopes, including the *fee* for materials.

Speech Therapy
Benefits are provided for the evaluation and treatment of *participants* who have voice, speech, language, swallowing, cognitive or hearing disorders. These services must be performed by a licensed and certified speech therapist as part of a treatment program which is appropriate for the *illness* or *injury*, and which is ordered by the attending *physician*.

***Physician's* Office Services**
Covered expenses include the following services rendered in a *physician's* office:

Office Visits
Benefits are provided for services given in a *physician's* office which are required for the diagnosis or treatment of an *illness* or *injury*. Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Allergy Care
Benefits are provided for allergy testing and physician services including injections, serums and extracts. Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Diagnostic X-ray and Laboratory Services
Benefits are provided for diagnostic x-ray and laboratory services given in a *physician's* office which are required for the diagnosis or treatment of an *illness* or *injury*. Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Chiropractic Care Services
Covered expenses include spinal manipulation and other related therapy treatments. *Chiropractic care* must be rendered for the active treatment of an *illness* or *injury*. Chiropractic X-Rays and Maintenance care are not covered.

Preventive Care Benefit
Covered expenses include these listed services for preventive care for each *participant*, subject to any limits described in the "Schedule of Benefits" section.

- **Gynecology Examination**;
- **Immunizations**;
- **Mammogram Test**;
- **Pap Test**;
- **Birth Control Drugs and Devices;**
- **Preventive Laboratory Screenings**;

- **General Medical Examination by a *Physician***;
- **Genetic Testing and Counseling in connection with BRCA Testing;**
- **Hearing Exam;**
- **Preventive X-rays**;
- **Prostate Exam**;
- **Sterilization procedures**; and
- **Well *Child* Care**.

Other Covered Expenses

Ambulance Service
Covered expenses include local professional ambulance service from your home to a *hospital*, or from the scene of an *accident* or medical *emergency*, to the nearest *institution* able to treat the condition.

Air ambulance services will be covered when *medically necessary* to transport the *participant* to the nearest *institution* capable of treating the *illness* or *injury*.

Home Health Care
Covered expenses include home health services when rendered by a licensed and accredited *home health care agency*. These services must be provided through a formal, written home health care treatment plan, certified as *medically necessary* by the attending *physician*, and approved by the *Plan*. Benefits are provided for:

- Skilled nursing care as provided by a licensed practical nurse or registered nurse who does not ordinarily live in your home and who is not a member of your immediate family.
- Physical, occupational, and speech therapy.
- Services provided by a home health aide.

On-going home health services will require re-certification by the attending *physician* and approval by the *Plan*, at the *Plan Administrator's* discretion, in order to qualify for continued coverage.

The total benefits paid for home health care on a weekly basis may not exceed the amount the *Plan* would have paid if the *participant* had been confined in a *hospital, skilled nursing facility* or other *institution*.

Hospice Care
Covered expenses include hospice care services for a terminally ill *participant* when provided by a *hospice care agency*. The services must be provided through a formal, written hospice care treatment program and certified by the attending *physician* as *medically necessary*. Benefits are provided for:

- *Room and board* for confinement in a licensed, accredited hospice facility.
- Services and supplies furnished by the hospice while the patient is confined.
- Part-time nursing care by or under the supervision of a registered nurse.
- Nutrition services and/or special meals.
- Respite services.
- Counseling services by a licensed social worker or a licensed counselor.

- Bereavement counseling by a licensed social worker or a licensed counselor for the *employee* and/or covered *dependent*(s).

The attending *physician* must certify that the *participant* is expected to continue to live for six months or less in order to qualify for this benefit.

If the *participant* lives beyond six months, the *Plan* will approve additional hospice care benefits on receipt of satisfactory evidence of the continued *medical necessity* of the services.

Other *Covered Expenses* Also Include:

- **Blood transfusions and blood products,** to the extent not replaced. The Plan will not cover expenses in connection with autologous blood acquisition and storage.
- **Oxygen**.
- ***Surgical* dressings, splints, casts**, and other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home, or that have a value in the absence of an *illness* or *injury*.
- **One set of lenses** (contact or frame-type) following *surgery* for cataracts.
- **Reconstruction of a breast**. The federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a *mastectomy*. The new federal law requires group health plans that provide *mastectomy* coverage to also cover breast reconstruction *surgery* and prostheses following *mastectomy*.

  As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a *medically necessary mastectomy* will also receive coverage for:

  - Reconstruction of the breast on which the *mastectomy* has been performed;
  - *Surgery* and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and physical complications from all stages of *mastectomy*, including lymphedamas;

  in a manner determined in consultation with the attending *physician* and the patient.

  This coverage will be subject to the same provisions that currently apply to *mastectomy* coverage, and will be provided in consultation with you and your attending *physician*;

- **Oral *surgical* procedures**, including:
  - Excision of tumors and cysts of the jaws, cheeks, lips, tongues, roof and floor of the mouth.
  - *Emergency* repair due to *injury* to sound natural teeth.
  - *Surgery* needed to correct accidental *injuries* to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
  - Excision of benign bony growths of the jaw and hard palate.
  - External incision and drainage of cellulitis.
  - Incision of sensory sinuses, salivary glands or ducts.

MEDICAL EXCLUSIONS AND LIMITATIONS

This Plan will not reimburse any expense that is not a *covered expense*. This *Plan* does not cover any charge for services or supplies:

- **Abortion.** That are *incurred* directly or indirectly as the result of an abortion except in the case of miscarriage, when the life of the mother would be threatened if the fetus were carried to term, or when complications arise.
- **Acne and other skin surgery.** Removal of benign growths, lesions, tumors or warts.
- **Acupuncture.**
- **Autopsy.**
- **Biofeedback.**
- **Cochlear implants.** For cochlear implants.
- **Cognitive Therapy.**
- **Consultation or Hospital Visit by the surgeon on the same day as surgery.**
- **Corrective shoes.** For corrective shoes.
- **Cosmetic surgery.** Including sclerosis.
- **Counseling.** For counseling, for:
  - Marital difficulties
  - Social maladjustment
  - Pastoral issues
  - Financial issues
  - Behavioral issues
  - Lack of discipline or other antisocial action.
- ***Custodial care.*** For *custodial care*, except as specified.
- **Dental.** That are related to dental treatment, except as specifically provided in this *Plan*.
- **Dental Services.**
- **Dental *hospital* admissions.** Related to dental *hospital* admissions, unless determined to be *medically necessary* because of a concomitant condition.
- **Dental prescriptions.** For dental prescriptions (e.g., Peridex, fluoride).
- **Deviated Septum.** Charges related to treatment of deviated septum.
- **Durable Medical Equipment.**
- **Eating disorders.** That are related to eating disorders (e.g., anorexia and bulimia).
- **Educational.** That are related to education or vocational training. This exclusion does not apply to educational services rendered for diabetic counseling, peritoneal dialysis, or any other educational service deemed to be *medically necessary* by the *Plan*.
- **Excess over semi-private rate.** That are in excess of the semi-private room rate, except as otherwise noted.

- **Excluded providers and facilities.** That are rendered or provided by the following excluded providers or facilities:
  - Hypnotists;
  - Naturopaths;
  - Rolfers; and
  - Marriage counselors.

- ***Experimental.*** That are *experimental.*
  - In some cases, the application of an established procedure, as a course of treatment for a specific condition, may be considered *experimental*, and hence, not covered by this *Plan*.
- **Eye exercises or training and orthoptics.** For eye exercises or training and orthoptics.
  - This exclusion does not apply to Aphakic patients.
  - This exclusion does not apply to soft lenses or sclera shells intended for use as corneal bandages.
  - This exclusion does not apply to one pair of lenses following cataract *surgery*.
  - This exclusion does not apply to benefits as noted in the Vision Care Benefits section.
- **Eyeglasses, contact lenses, refractions.** For eyeglasses, contact lenses and refractions, or the examination for their prescription and fitting, except one pair of lenses following surgery for cataracts.
- **Food supplements.** Related to food supplements or augmentation, in any form (unless *medically necessary* to sustain life in a critically ill person).
- **Foot care services, routine.** For routine foot care, including, but not limited to, cutting or removal of corns or calluses, the trimming of nails and other hygienic and preventive and maintenance care, performed in the absence of localized *illness*, *injury* or symptoms involving the foot.
- **Growth hormone therapy.** For growth hormone therapy.
- **Hearing aids.** For hearing aids or devices, or the examination for their prescription and fitting.
- **Home Visits.** For physician services provided in the home.
- **Infusion Therapy.** For drugs and supplies used for Infusion Therapy.
- **Impotence; sexual dysfunction.** For impotence and sexual dysfunction treatment and medications, including, but not limited to, penile implants, sexual devices or any medications or *drugs* pertaining to sexual dysfunction or impotence.
- **Infertility treatment.** For infertility treatment, including, but not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), fertility *drugs*, artificial insemination, zygote intrafallopian transfer (ZIFT), reversal of a sterilization procedure, surrogate mother or donor eggs.
- **Injections.** Other than immunizations and allergy treatment, injections are not covered.
- **Marital counseling.** For marital counseling.
- **Massage therapy.** For massage therapy, unless applied in conjunction with other active physical therapy modalities for a specific covered *illness* or *injury*, and approved as *medically necessary* by the *Plan Administrator*.
- **Medically unnecessary.** That are not *medically necessary* for the care and treatment of an *injury* or *illness*, except where otherwise specified, or are not accepted as standard practice by the American Medical Association or the Food and Drug Administration.
- **Mental Health.** Services rendered for the treatment of mental illness.
- ***Never Events*.** In addition, serious preventable adverse events ("***never events***") will, in no event be covered under the *Plan*. These *never events* include:

- *Surgery* performed on the wrong body part;
- *Surgery* performed on the wrong patient;
- Wrong *surgical procedure* performed on a patient;
- Unintentional retention of a foreign object in a patient after *surgery* or other procedure;
- Inoperative or immediate postoperative death in an ASA Class I patient;
- Patient death or serious disability associated with the use of contaminated *drugs*, devices, or biologics provided by the healthcare facility;
- Patient death or serious disability associated with the use or function of a device in a patient in which the device is used or functions other than as intended;
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility;
- Infant discharged to the wrong person;
- Patient death or serious disability associated with patient leaving the facility without permission;
- Patient suicide, or attempted suicide resulting in a serious disability, while being cared for in a healthcare facility;
- Patient death or serious disability associated with a medication error (e.g. error involving the wrong *drug*, wrong dose, wrong patient, wrong time, wrong rate, wrong preparations, or wrong route of administration);
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products;
- Maternal death or serious disability associated with labor and delivery in a low-risk pregnancy while being cared for in a healthcare facility;
- Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility;
- Death or serious disability associated with failure to identify and treat hyperbilirubinemia (condition where there is a high amount of bilirubin in the blood) in newborns;
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility;
- Patient death or serious disability due to spinal manipulative therapy;
- Artificial insemination with the wrong donor sperm or wrong egg;
- Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility;
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
- Patient death or serious disability associated with a burn *incurred* from any source while being cared for in a healthcare facility;
- Patient death associated with a fall while being cared for in a healthcare facility;
- Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility;
- Any instance of care ordered by or provided by someone impersonating a *physician*, nurse, pharmacist, or other *provider*;
- Abduction of patient of any age;

- Sexual assault of a patient within or on the grounds of a healthcare facility; and
- Death or significant *injury* of a patient or staff member resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare facility.

- **Non-prescription medicines and supplies.** That can be purchased without a prescription from a licensed *physician*.
- **Obesity treatment.** For the purpose of weight loss. This exclusion does not apply to benefits for surgical or non-surgical treatment of *morbid obesity* under a treatment plan that has been approved by the *Plan Administrator*.
- **Organ Transplant.** All services related to Organ Transplantation.
- **Orthotics.**
- **Orthognathic *surgery*** (jaw realignment *surgery*) to correct retrognathia, apertognathia, prognathism, open bite malocclusion, or transverse skeletal deformities.
- **Patient convenience.** Related to the modification of homes, vehicles or personal property to accommodate patient convenience. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment and cervical pillows. This exclusion also applies to any services or supplies that are provided during a course of treatment for an *illness* or *injury* that are solely for the personal comfort and convenience of the patient.
- **Personal hygiene.** For personal hygiene or convenience items.
- **Podiatry Services.** Other than acute foot injuries. Care of corns, bunions, calluses, nails of the feet, flat feet, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet are not covered expenses.
- **Prenatal vitamins.** For prenatal vitamins.
- **Preventive care.** For physical examinations, routine and preventive care, except as specifically provided under this *Plan*.
- **Prosthetics.**
- **Residential care facility.** Provided by or at a residential care facility or halfway house.
- **R.N. and L.P.N.** private duty nursing services.
- **Sex change.** Expenses for all services and supplies in connection with sex change operations or procedures.
- **Sleep Disorders.** Other than sleep apnea.
- **Specialty Drugs. For** Oral and Injectable drugs.
- **Substance / Alcohol Use.** Services rendered for the treatment of Substance or Alcohol Abuse.
- **Therapy.** That are related to aversion therapy, hypnosis therapy, primal therapy, rolfing, psychodrama or megavitamin therapy.
- **Travel.** For travel, even though prescribed by a *physician*.
- **TMJ.** Treatment of Temporomandibular Joint Disorder.
- **Trusses, corsets and other support devices including Physical Therapy supplies.**
- **Vision correction.** For radial keratotomy, keratomileusis or other vision correction procedures.
- **Vitamins.** For vitamins, except as specifically provided under this *Plan.*

- **Weekend admissions.** For weekend admission (Friday, Saturday or Sunday) to a *hospital* unless due to an *emergency* or if *surgery* is performed within 24 hours of admission.
- **Without approval.** Furnished without recommendation and approval of a *physician* acting within the scope of his or her license.
- **Work-related *illness* or *injury.*** Related to an *illness* or *injury* for which the *participant* is entitled to benefits under any workers' compensation or similar law.

COST CONTAINMENT PROVISIONS

Pre-certification Program for *Inpatient* Services
Inpatient care is normally the greatest part of the *Plan's* expenses and can be the most critical part of your treatment. Through the *Plan's* Pre-certification Program, it is possible to work with your attending *physician* to arrange for care in a setting that is more comfortable for you, such as your home, and to save both you and the *Plan* unnecessary expense.

The program works by establishing a communication among you, your attending *physician* and the Pre-certification Program administrator to discuss the proposed course of treatment and any options that may be available for your treatment. The Pre-certification Program does not establish your eligibility for coverage under the *Plan*, nor does it approve the services for coverage or reimbursement under the *Plan*. Those responsibilities rest with the *Plan Administrator*.

Because communication is the basis for the program, the *Plan* requires that you or your physician or facility contact the Pre-certification Program administrator at least 7 days before any non-*emergency inpatient* admission if possible; if not, contact the program administrator as soon as possible before your admission. The contact may be made by you, a friend or family member, or your *physician* or facility. It is the responsibility of Empire participating facilities to obtain pre-certification for services rendered on an in-patient basis. Failure to do so will result in a penalty to the provider for which the patient has no financial responsibility.

Urgent Care or *Emergency* Admissions

Do not delay seeking medical care for any *participant* who has a serious condition that may jeopardize his life or health because of the requirements of this Program. For urgent, *emergency* admissions, follow your *physician's* instructions carefully, and contact the Pre-certification Program administrator within 3 days of the admission. No penalty will be applied to your benefits if contact is made within this time period.

Since the *Plan* does not require you or a covered *dependent* to obtain approval of a medical service prior to getting treatment for an urgent care or *emergency* situation, there are no *"pre-service urgent care claims"* under the *Plan*. In an urgent care or *emergency* situation, you or a covered *dependent* simply follow the *Plan*'s procedures following the treatment and file the claim as a *"post-service claim."*

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not 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). Notification is still encouraged at the time of admission, and is required for any *hospital* stay that is in excess of the minimum length of stay.

Concurrent *Inpatient* Review
Once the *inpatient* setting has been pre-certified, the on-going review of the course of treatment becomes the focus of the Program. Working directly with your *physician*, the Pre-certification Program administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

The Pre-certification Program administrator will not interfere with your course of treatment or the physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

The Pre-certification Program administrator for this *Plan* is:

American Health Holding, Inc. ("AHH") 1-866-317-5386

A pre-certification or concurrent review determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this *Plan* and the decision of the *Plan Administrator* in its sole discretion.

Inpatient Services
It is the responsibility of Empire participating facilities to obtain pre-certification for services rendered on an in-patient basis. Failure to do so will result in a penalty to the provider for which the patient has no financial responsibility.

Pre-certification Program for Outpatient Services
The Plan's Pre-certification Program also includes certain outpatient services. These typically are services that may not be *covered expenses* or that involve an on-going course of treatment on an outpatient basis. The purpose of pre-certifying these services is to identify non-*covered expenses*, or *Plan* limitations, in advance of incurring the expenses.

The Program works by establishing a communication among you, your attending *physician,* and the Pre-certification Program administrator, to discuss the proposed course of treatment and any options that may be available for your treatment. The Pre-certification Program does not establish your eligibility for coverage under the *Plan*, nor does it approve the services for coverage or reimbursement under the *Plan*. Those responsibilities rest with the *Plan Administrator*.

Because communication is the basis for the Program, the *Plan* recommends that you contact the Pre-certification Program administrator at least 7 days before the commencement of non-*emergency* services of the types listed in this section. The contact may be made by you, a friend or family member, or your *physician* or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. **Failure to contact the Program administrator prior to commencing services may result in the denial of your claim**

Urgent or *Emergency* Care
Do not delay seeking medical care for any *participant* who has a serious condition that may jeopardize his life or health because of the requirements of this Program. Pre-certification of outpatient *emergency* care is not recommended or required under these circumstances.

Since the *Plan* does not require you or a covered *dependent* to obtain approval of a medical service prior to getting treatment for an urgent care or *emergency* situation, there are no "*pre-service urgent care claims"* under the *Plan*. In an urgent care or *emergency* situation, you or a covered *dependent* simply follow the *Plan*'s procedures following the treatment and file the claim as a "*post-service claim."*

Concurrent Outpatient Review
Once the outpatient treatment has pre-certified, the on-going review of the course of treatment becomes the focus of the Program. Working directly with your *physician*, the Pre-certification Program administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

The Pre-certification Program administrator will not interfere with your course of treatment or the physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

Non-*emergency* outpatient care and services of the types listed below require pre-certification:

- CAT Scan.
- Chemotherapy.
- Dialysis.
- Genetic Counseling/Testing (BRCA).
- *Home health care* services.
- *Hospice* care services.
- Magnetic resonance imaging ("MRI").
- Outpatient Diagnostic Procedures – Cat Scan, SPECT.
- Physical Medicine (Physical, Speech, Occupational).
- Pain management programs.
- Radiation Therapy.
- Positron emission tomography (PET) / SPECT scan.
- Speech therapy.
- Ambulatory Surgical Procedures.

Penalty
If you fail to notify the Pre-certification Program administrator prior to receiving non-emergency outpatient services the claim may be denied.

A pre-certification or concurrent review determination by the *Plan* under this provision will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this *Plan* and the decision of the *Plan Administrator* in its sole discretion.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Prescription Drug Card Program	
Deductible	$200 per Individual / $600 per Family
Prescription Drug Card Program — Generic Retail and Mail Order	100% after $15 copayment Retail , maximum 30 day or 120 units / $30 copayment Mail Order, maximum 90 day supply or 360 units, whichever is lesser
Prescription Drug Card Program — Brand Name Retail and Mail Order	100% after $35 copayment Retail, maximum 30 day or 120 units/ $70 copayment Mail Order, maximum 90-day supply or 360 units, whichever is lesser
Prescription Drug Card Program — Non-Formulary Drugs - Retail and Mail Order	100% after $75 copayment Retail / $150 Mail Order Maximum supply based on point of purchase
Specialty Drugs – Infusion / Injectibles	Not Covered

Benefits are provided for the purchase of *drugs* through the *Plan's* Prescription Drug Card Program. The *participant* must purchase the prescription *drugs* through the Prescription Drug Card Program, and use either a participating pharmacy or the "mail order option."

Prescription *drugs* that are not purchased through the *Plan's* Prescription Drug Card Program will not be *covered expenses* and are not eligible for reimbursement.

The *Plan's* Prescription Drug Card Program is administered by Broadreach Medical Resources (BMR) and Affordable Scripts Mail Order. Both Prescription Benefit Managers have a network of pharmacies which can identify *participants* and the *Plan's* coverage provisions. To find out which pharmacies participate, contact BMR at 866-718-2375 or visit the website at BMR-INC.com. Affordable Scripts mail order can be reached at 516-561-6480.

Covered Prescriptions
Under the Prescription Drug Card Program, *covered expenses* include:

- Federal legend *drugs*.
- State-restricted *drugs*.
- Insulin.
- Birth control drugs and devices.
- Smoking Cessation products.
- Preventive and Women's Health products.
- Vaccines

Certain *drugs* are not covered, even when prescribed by your *physician*. Please refer to the list of "Excluded Drugs" below.

How the Program Works
There are two ways to purchase drugs through the *Plan's* Prescription Drug Card Program. You may save money by using the "mail order option" if you have prescription *drug(s)* that you must take on an on-going basis.

- To fill a prescription at a participating pharmacy (the "pharmacy option"), simply present your *Plan* ID card and pay your portion of the cost (shown in the "Schedule of Benefits"). The pharmacist will file the claim for you.

- To fill a prescription through the Drug Card Program's "mail order option":
  - Obtain a copy of the mail order form from Affordable Scripts.

- Complete the patient profile questionnaire (for your first order only).
- Ask your *physician* to prescribe the needed medication for a 90-day supply, plus refills.
- If you are presently taking medication, you will need a new prescription.
- If you need the medication immediately, **but will be taking it on a continuing basis,** ask your *physician* for two prescriptions: one for a 14-day supply that you can have filled at a local pharmacy, and one for the balance of the prescription, up to a 90-day supply, that you can submit through the "mail order option."
- Send the completed patient profile questionnaire to the address on the form with your original prescription(s), along with your check for payment of your portion of the cost (shown in the "Schedule of Benefits").

Once your order is processed, it will be sent to you via First Class Mail and it will include instructions for the re-order of future prescriptions and/or refills.

Excluded *Drugs*
The *Plan* will not cover the following *drugs*, even when prescribed by the *participant's physician*:

- **Anorexiants** (weight control *drugs*)**.**
- **Brand Name drugs which can be purchased generically.**
- ***Experimental* or investigational *drugs,*** including compounded medications for non-FDA-approved use.
- ***Drugs* which are not *medically necessary* for the treatment of an *illness, injury* or *pregnancy*.**
- **Fertility medications.**
- **Fluoride (limited to dependents under age 16).**
- **Growth hormones.**
- **Drugs or Agents for Impotency.**
- **Injectable drugs.**
- **Infusion drugs and supplies.**
- **Oxygen (including administration).**
- **Provided in or through a *Physician's* office** (*drugs* intended for use in a setting other than the *physician's* office).
- **Retin A.**
- **Rogaine.**
- **Syringes and/or disposable needles.**
- **Therapeutic devices** or appliances, support garments, and other non-medical substances.
- **Vitamins,** except prenatal.
- **Workers' Compensation:** prescriptions which an eligible person is entitled to receive, without charge, under any workers' compensation law, or under any municipal, state or federal program.

SCHEDULE OF VISION CARE BENEFITS

Maximum Benefits
The United Workers Health Fund has contracted with an outside service (Vision Screening, Inc.) whose participating providers agree to accept our allowance as payment in full. Covered services include:

- Eye Examination by a licensed optometrist;
- One pair of eyeglasses complete with frame and single vision, bifocal or trifocal lenses;
- Contact Lenses

Maximum Benefits for:	
All Vision Care Services	$75 once every 12 months

VISION CARE COVERED EXPENSES

The following is a brief description of the types of expenses that will be considered for coverage under the *Plan*. Coverage will be limited to *usual, customary and reasonable fees*. Please refer to the section, "Schedule of Vision Care Benefits" for information concerning benefit payment and limits, and the section, "Exclusions and Limitations" for information concerning non-*covered expenses*.

- Eye examinations, including refraction.
- Single vision lenses for frames.
- Bifocal vision lenses for frames.
- Trifocal vision lenses for frames.
- Lenticular vision lenses for frames.
- Contact lenses, including disposable contact lenses.
- Frames.

VISION CARE EXCLUSIONS AND LIMITATIONS

This *Plan* does not cover any charge for the following services or supplies:

- **Charges for completion of forms.** Charges for completion of a claim forms;
- **Charges for failure to keep appointment.** Charges for failure to keep a scheduled visit;
- **Consultations by phone.** Phone consultations;
- **Government provided**. Charges for vision care paid for or provided by the laws of any government or treatment given in a government-owned facility, unless the *employee* or *dependent* is legally required to pay;
- **Non-prescription lenses.** Charges for lenses ordered without a prescription;
- **Orthoptics.** Charges for orthoptics (eye muscle exercises);
- **Prior to or after coverage.** Care, treatment or supplies for which a charge was *incurred* before or after a person was covered under this Plan;
- **Radial keratotomy.** Radial keratotomy or other surgeries on the cornea in lieu of eyeglasses;
- **Replacements.** Replacement of lost or broken lenses or frames, including contact lenses, except as provided for each service in the section, "Schedule of Vision Care Benefits";
- **Safety goggles or sunglasses.** Charges for safety goggles or sunglasses, including prescription type; and
- **Vision training.** Charges for vision training or subnormal vision aids.

DEATH BENEFIT

This benefit covers active employees only.

In the event of your death, your beneficiary or beneficiaries will receive a $10,000 Death Benefit from the Fund.

Your beneficiary
When your coverage starts, you will be given an enrollment card on which you designate the beneficiary or beneficiaries who will receive this benefit if you die. You may change your beneficiary or beneficiaries at any time – the cards are available from the Fund Office.

If you do not name a beneficiary, or if your beneficiary dies before you, your death benefit will be paid to your estate.

GENERAL EXCLUSIONS AND LIMITATIONS

This section applies to all benefits provided under any section of this *summary plan description.* This *Plan* does not cover any charge for services or supplies:

- **Absence of coverage.** That would not have been made in the absence of coverage.
  - This includes charges that are submitted to the *Plan* equal to any amount for which the *provider* has discounted fees or has "written off" amounts due.
- **Civil insurrection or riot.** Resulting from *injuries* incurred or exacerbated while participating in a civil insurrection or riot**.**
- **Complications.** That result from complications arising from a non-covered *illness* or *injury*, or from a non-covered procedure. This exclusion does not apply to *complications of pregnancy*.
- ***Cosmetic*.** For *cosmetic surgery* or procedures, or aesthetic services (including complications arising therefrom).
  - This exclusion does not apply to procedures required as the result of an *injury*, or if approved as *medically necessary* for a covered *illness*.
  - This exclusion does not apply to reconstruction of a breast following a *mastectomy*, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a *mastectomy*, including lymphademas, in a manner determined in consultation with the attending *physician* and the *participant.*
- **Court-ordered services.** That are ordered by a court, unless determined by the *Plan Administrator*, in its discretion, to otherwise be appropriate and covered.
- **Deductibles, Copayments and Coinsurance.** That are not payable due to the application of any specified deductible, copayment or coinsurance provisions of the *Plan.*
- **Excess.** That are not payable under the *Plan* due to application of any *Plan* maximum or limit or because the charges are in excess of the *Plan Administrator's* allowance for the particular service or supply.
- **Forms.** For the completion of medical reports, claim forms or itemized billings.
- **Government services.** To the extent paid, or which the *participant* is entitled to have paid or obtain without cost, by or through any government, or division thereof, except a program for civilian employees of a government.
- **Hazardous Hobby.** For any condition, *illness* or *injury*, or complication thereof, arising out of engaging in a hazardous hobby or activity, which is an unusual activity characterized by a constant threat of danger, such as skydiving, auto or airplane racing, hang gliding, bungee jumping, mountain or rock climbing, or parachuting, water or snow skiing, deep sea diving, jet ski operating, or snowmobiling, motorcycling, and all-terrain vehicle riding.
- **Illegal act.** Related to *injuries* sustained, or an *illness* contracted, during the commission, or attempted commission, of a criminal activity.
- **Immediate relative.** Provided by an *immediate relative* or an individual residing in your home.
- **Late Claims.** For which the claim is received by the *Plan* after the maximum period allowed under this *Plan* for filing claims has expired.
- **Malpractice.** That are required as a result of malpractice, malfeasance or misfeasance or that are to treat *injuries* that are sustained or an *illness* that is contracted, including infections and complications, while the *participant* was under the care of a provider for a condition wherein such *illness, injury*, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator* in its sole discretion, gave rise to the expense.

- **Military service.** Resulting from, or prolonged as a result of, performing a duty as a member of the military service of any state or country.
- **Missed appointments.** Related to missed appointments.
- **No legal obligation.** That are provided to a *participant* for which the *provider* customarily makes no direct charge or for which the *participant* is not legally obligated to pay.
- **Not actually rendered.** That are not actually rendered.
- **Not eligible.** That were rendered or received prior to or after any period of coverage under this *Plan,* except as specifically provided for in this *summary plan description*.
- **Not specifically covered.** That are not specifically covered under the *Plan.*
- **Outside of the U.S.A.** For any care, services, *drugs* or supplies *incurred* outside of the U.S.A. if the *participant* traveled to such a location for the purpose of obtaining the care, services, *drugs* or supplies.
- **Penalties.** That are related to failure to comply with any requirements for coverage under this *Plan*, or for any copayment amounts identified as a "penalty" in this *summary plan description*.
- **Prohibited by law.** For which the *Plan* is prohibited by law or regulation from providing benefits.
- **Self-inflicted.** Resulting from any intentionally self-inflicted *illness* or *injury* unless resulting from an underlying medical condition (including physical or mental health conditions).
- **Subrogation, Reimbursement, and/or Third Party Responsibility**. Services, supplies, care, and/or treatment of an *injury* or *sickness* not payable by virtue of the *Plan's* subrogation, reimbursement, and/or third party responsibility provisions.
- **Tax and shipping.** For taxes and shipping charges levied on *medically necessary* items and services. This exclusion does not apply to surcharges required by law to be paid by the *Plan* in applicable states.
- **Telephone consultations.** For telephone consultations**.**
- **War.** Resulting from war or an act of war, whether declared or undeclared, or any act of aggression, and any complication therefrom.
- **Work-related *illness* or *injury.*** Related to an *illness* or *injury* arising out of, or in the course of, any employment for wage or profit, including that of previous employers or while self-employed, which is covered under workers' compensation laws.

With respect to any *injury* which is otherwise covered by the *Plan*, the *Plan* will not deny benefits provided for treatment of the *injury* if the *injury* results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

TERMINATION OF COVERAGE

When does my participation end?
Your participation will end at midnight on the earliest of the following dates:

- The date the *Plan* terminates;
- The last day of the month for which you request that your coverage be terminated, provided your request is made on or before that date;
- If you fail to make any contribution when it is due, the last date of the period for which you or your employer made a contribution;
- The last day of the month in which you cease to be eligible for coverage under the *Plan*;
- The last day of the month in which you terminate employment; or
- The date on which an *employee* or his *dependent* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information.

When does participation end for my *dependents*?
The coverage for your *dependents* will end at midnight on the earliest of the following dates:

- The date the *Plan* terminates;
- The last date of the month in which the *Plan* discontinues coverage for *dependents*;
- The last date of the month in which your coverage terminates;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution for your *dependents*;
- In the case of a *child* age 26 or older for whom coverage is being continued due to mental or physical inability to earn his own living, the last day of the month in which earliest of the following events occurs:
  - Cessation of the inability;
  - Failure to furnish any required proof of the uninterrupted continuance of the inability or to submit to any required examination; or
  - Upon the *child*'s no longer being *dependent* on you for his support;
- The last date of the month in which person ceases to be a *dependent*; or
- The date on which an *employee* or his *dependent* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information.]

Will the *Plan* provide evidence of coverage?
The *Plan* generally will automatically provide a *certificate of coverage* to anyone who loses coverage in the *Plan*. In addition, a *certificate of coverage* will be provided upon request at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the *Plan*.

The *Plan* will make reasonable efforts to collect information applicable to any *dependents* and to include that information on the *certificate of coverage*, but the *Plan* will not issue an automatic *certificate of coverage* for *dependents* until the *Plan* has reason to know that a *dependent* has lost coverage under the *Plan*.

May I continue participation during *FMLA leave*?
The Family and Medical Leave Act is a federal law that applies, generally, to employers with 50 or more employees, and provides that an eligible *employee* may elect to continue coverage under this *Plan* during a period of approved *FMLA leave* at the same cost as if the *FMLA leave* not been taken.

If provisions under the *Plan* change while you are on *FMLA leave*, the changes will be effective for you on the same date as they would have been had you not taken leave.

Am I an eligible *employee*?
You are an eligible *employee* if all of the following conditions are met:

- You have been employed with the *participating employer* for at least 12 months;
- You have been employed with the *participating employer* at least 1,250 hours during the 12 consecutive months prior to the request for *FMLA leave*; and
- You are employed at a worksite that employs at least 50 employees within a 75-mile radius.

What circumstances qualify for *FMLA leave*?
Coverage under *FMLA leave* is limited to a total of 12 workweeks during any 12-month period that follows:

- The birth of, and to care for, your *son or daughter*;
- The placement of a *child* with you for adoption or foster care;
- Your taking leave to care for your *spouse*, *son* or *daughter*, or *parent* who has a *serious health condition*; or
- Your taking leave due to a *serious health condition* which makes you unable to perform the functions of your position.
- A *qualifying exigency* arising out of the fact that a *spouse*, *son or daughter*, *parent*, or *next of kin of covered service member* is a regular component, reserve component, or *covered veteran* of the Armed Forces.

Coverage under *FMLA leave* is limited to a total of 26 workweeks during any 12-month period for the following situations:

- To care for a service member following a s*erious illness or injury* to that service member, when the *employee* is that service member's *spouse, son or daughter, parent,* or *next of kin of covered service member*.
- To care for a veteran who is undergoing medical treatment, recuperation, or therapy for a *serious illness or injury* that occurred any time during the five years preceding the date of treatment, when the *employee* is that veteran's *spouse*, *son or daughter*, *parent*, or *next of kin of covered service member.*

This leave may be paid (accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid. Your *participating employer* has the right to require that all paid leave be used prior to providing any unpaid leave.

You must continue to pay your portion of the *Plan* contribution, if any, during the *FMLA leave*. Payment must be made within 30 days of the due date established by the *Plan Administrator*. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

What are the notice requirements for *FMLA leave*?
You must provide at least 30 days' notice to your *participating employer* prior to beginning any leave under *FMLA*. If the nature of the leave does not permit such notice, you must provide notice of the leave as soon as possible. Your *participating employer* has the right to require medical certification to support your request for leave due to a *serious health condition* for yourself or your eligible family members.

How long may I take *FMLA leave*?
During any one 12-month period, the maximum amount of *FMLA leave* may not exceed 12 workweeks for most *FMLA* related situations. The maximum periods for an *employee* who is the primary care giver of a service member with a *serious illness or injury* that was *incurred* in the line of active duty may take up to 26 weeks of *FMLA leave* in a single 12-month period to care for that service member. Your *participating employer* may use any of four methods for determining this 12-month period.

If you and your *spouse* are both employed by the *participating employer*, *FMLA leave* may be limited to a combined period of 12 workweeks, for both *spouses*, when *FMLA leave* is due to:

- The birth or placement for adoption or foster care of a *child*; or
- The need to care for a *parent* who has a *serious health condition*.

Will *FMLA leave* terminate before the maximum leave period?
Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

- When you inform your *participating employer* of your intent not to return from leave;
- When your employment relationship would have terminated but for the leave (such as during a reduction in force);
- When you fail to return from the leave; or
- If any required *Plan* contribution is not paid within 30 days of its due date.

If you do not return to work when coverage under *FMLA leave* ends, you will be eligible for *COBRA* continuation of coverage at that time.

Recovery of *Plan* contributions
Your *participating employer* has the right to recover the portion of the *Plan* contributions it paid to maintain coverage under the *Plan* during an unpaid *FMLA leave* if you do not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a *serious health condition* that entitles you to *FMLA leave* (in which case your *participating employer* may require medical certification) or other circumstances beyond your control.

Will my coverage be reinstated when I return to work?
The law requires that coverage be reinstated upon your return to work following an *FMLA leave* whether or not you maintained coverage under the *Plan* during the *FMLA leave*.

On reinstatement, all provisions and limits of the *Plan* will apply as they would have applied if *FMLA leave* had not been taken. The *waiting period* will be credited as if you had been continually covered under the *Plan*.

Definitions
For this provision only, the following terms are defined as stated.

"Activities of Daily Living" shall include, but are not limited to adaptive search activities such as caring appropriately for one's grooming and hygiene, bathing, dressing, and eating.

"Covered Veteran" shall mean a member of the armed forces, National Guard, or reserves who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes *FMLA leave* to care for the *covered veteran*.

"Incapable of Self-Care" means that the *parent* requires active assistance or supervision to provide daily self-care in three or more of the "*activities of daily living*" or "*instrumental activities of daily living.*"

"Instrumental Activities of Daily Living" shall include, but are not limited to cooking, cleaning, shopping, taking public transportation, paying bills, maintaining a residence, using telephones and directories, using a post office, etc.

"Next of Kin of Covered Service Member" shall mean the nearest blood relative, other than the covered service member's *spouse, parent, son or daughter*, in the following order of priority: blood relatives who have been granted legal custody of the service member by court decree or statutory provisions, brothers and sisters, grandparents, aunts and uncles, and first cousins, unless the covered service member has specifically designated in writing another blood relative as his or her nearest blood relative for purposes of military caregiver leave under *FMLA*.

"Parent" is your biological parent or someone who has acted as your parent in place of your biological parent when you were a *son* or *daughter*.

"Qualifying Exigency" includes the following situations:

- Short-notice deployment.
    - To address any issue that arises from the fact that a covered military member is notified seven or less calendar days prior to the date of deployment of an impending call or order to active duty in support of a contingency operation; and
    - Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to active duty in support of a contingency operation;
- Military events and related activities.
    - To attend any official ceremony, program, or event sponsored by the military that is related to the active duty or call to active duty status of a covered military member; and
    - To attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member;
- Parental Care.
    - To arrange for alternative care for a *parent* of the military member when the *parent* is *incapable of self-care* and the covered active duty or call to covered active duty status of the military member necessitates a change in the existing care arrangements;
    - To provide care for a *parent* of the military member on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the *parent* is *incapable of self-care* and the need to provide such care arises from covered active duty or call to covered active duty status of the military member;
    - To admit or transfer a *parent* of the military member to a care facility when the admittance or transfer is necessitated by the covered active duty or call to covered active duty status of the military member; and

- To attend meetings with staff at a care facility for the *parent* of the military member, such as meeting with hospice or social service providers, when such meetings are necessitated by the covered active duty or call to covered active duty status of the military member basis (but not on a routine, regular, or everyday basis).

- Childcare and school activities.

  - To 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;

  - To 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;

  - To enroll in or transfer to a new school or daycare 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

  - To 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.

  - To 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

  - To 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. 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. To spend time with a covered military member who is on short-term, temporary, rest and recuperation leave during the period of deployment. Eligible *employees* may take up to 15 days of leave for each instance of rest and recuperation;

- Post-deployment activities.

  - 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; and

  - 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; and

- Additional activities. To address other events which arise out of the covered military member's active duty or call to active duty status provided that the *participating employer* and *employee* agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

"Serious Health Condition" is an *illness*, *injury*, impairment, or physical or mental condition that involves:

- Inpatient care in a *hospital*, hospice, or residential medical facility; or

- Continuing treatment by a health care provider (a doctor of medicine or osteopathy who is authorized to practice medicine or *surgery*, as appropriate, by the state in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services).

"Serious Illness or Injury" for a current member of the Armed Forces is defined as an *illness* or *injury incurred* in the line of duty of the Armed Forces, or that existed before the beginning of the member's active duty and was aggravated by the service in the line of duty on active duty in the Armed Forces and that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating.

"Serious Illness or Injury" of a veteran is defined as an *illness* or *injury incurred* in the line of duty of the Armed Forces and manifested itself before or after the service member became a Veteran, and is:

- A continuation of a *serious illness or injury* that was *incurred* or aggravated when the *covered veteran* was a member of the Armed Forces and rendered the service member unable to perform the duties of the service member's office, grade, rank, or rating; or a physical or mental condition for which the *covered veteran* has received a US Department of Veterans Affairs Service-Related Disability Rating of 50 percent or greater, and such rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or

- A physical or mental condition that substantially impairs the *covered veteran's* ability to secure or follow a substantially gainful occupation by reason of disability or disabilities related to military service, or would do so absent treatment; or

- An *injury*, including a psychological *injury*, on the basis of which the *covered veteran* has been enrolled in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.

"Son or Daughter" means a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing 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.

"Son or Daughter" of a covered service member means a covered service member's biological, adopted, or foster child, stepchild, legal ward, or a child for whom the covered service member stood in loco parentis, and who is of any age.

"Son or Daughter" of covered active duty or call to covered active duty status means the *employee's* biological, adopted, or foster child, stepchild, legal ward, or a child for whom the *employee* stood in loco parentis, who is on covered active duty or call to covered active duty status, and who is of any age.

"Spouse" means a husband or wife as defined or recognized under State law for purposes of marriage in the State where the *employee* resides, including common law marriage in States where it is recognized.

NOTE: For complete information regarding your rights under *FMLA*, contact your *participating employer*.

May I continue participation while I am absent under *USERRA*? Will my coverage be reinstated on return from *USERRA* leave?
If you are absent from employment because you are in the *uniformed services*, you elect to continue your coverage under this Plan for up to 24 months. If you elected to continue coverage under USERRA before December 10, 2004, the maximum period for continuing coverage is 18 months. To continue your coverage, you must comply with the terms of the *Plan* and pay your contributions, if any. In addition, *USERRA* also requires that, regardless of whether you elected to continue your coverage under the *Plan*, your coverage and your *dependents'* coverage be reinstated immediately upon your return to employment, so long as you meet certain requirements contained in *USERRA*. Contact your *participating employer* for information concerning your eligibility for *USERRA* and any requirements of the *Plan*.

COBRA Continuation Coverage
The right to *COBRA continuation coverage* was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("*COBRA*"). *COBRA continuation coverage* can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the *Plan* when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if you or your *dependents* fail to make timely payment of premiums. You should check with your *participating employer* to see if *COBRA* applies to you and your *dependents*.

What is *COBRA continuation coverage*?
"*COBRA continuation coverage*" is a continuation of *Plan* coverage when coverage otherwise would end because of a life event known as a "*qualifying event*." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your *participating employer's* plan) are not considered for continuation under *COBRA*.

What is a *Qualifying Event*?
Specific *qualifying event*s are listed below. After a *qualifying event*, *COBRA continuation coverage* must 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 a *covered employee* (meaning that you are an employee and are covered under the *Plan*), you will become a *qualified beneficiary* if you lose your coverage under the *Plan* because either one of the following *qualifying event*s happens:

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

If you are the spouse of a *covered employee*, you will become a *qualified beneficiary* if you lose your coverage under the *Plan* because any of the following *qualifying event*s happens:

- 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.

Your *dependent children* will become *qualified beneficiaries* if they lose coverage under the *Plan* because any of the following *qualifying event*s happens:

- The parent-*covered employee* dies;
- The parent-*covered employee*'s hours of employment are reduced;
- The parent-*covered employee*'s employment ends for any reason other than his or her gross misconduct;
- The parent-*covered 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*."

The *participating employer* must give notice of some *qualifying events*
When the *qualifying event* is the end of employment, reduction of hours of employment, death of the *covered employee*, or the *covered employee*'s becoming entitled to *Medicare* benefits (under Part A, Part B, or both), the *participating employer* must notify the *Plan Administrator* of the *qualifying event*.

You must give notice of some *qualifying events*
Each *covered employee* or *qualified beneficiary* is responsible for providing the *Plan Administrator* with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

- Notice of the occurrence of a *qualifying event* that is a divorce or legal separation of a *covered employee* (or former employee) from his or her spouse;
- Notice of the occurrence of a *qualifying event* that is an individual's ceasing to be eligible as a *dependent* under the terms of the *Plan*;
- Notice of the occurrence of a second *qualifying event* after a *qualified beneficiary* has become entitled to *COBRA continuation coverage* with a maximum duration of 18 (or 29) months;
- Notice that a *qualified beneficiary* entitled to receive *COBRA continuation coverage* with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of *COBRA continuation coverage*; and
- Notice that a *qualified beneficiary*, with respect to whom a notice described in the bulleted item above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The *Plan Administrator* is:

Board of Trustees of the United Workers Health Fund Comprehensive Health Plan
50 Charles Lindbergh Blvd., Suite 207
Uniondale, NY 11553
(877) 347-7225

A form of notice is available, free of charge, from the *Plan Administrator* and must be used when providing the notice.

What is the deadline for providing the notice?
For *qualifying event*s described above, the notice must be furnished by the date that is 60 days after the latest of:

- The date on which the relevant *qualifying event* occurs;
- The date on which the *qualified beneficiary* loses (or would lose) coverage under the *Plan* as a result of the *qualifying event*; or
- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan*'s *summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan*'s procedures for providing such notice to the *Plan Administrator*.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a *qualifying event* occurs;
- The date on which the *qualified beneficiary* loses (or would lose) coverage under the *Plan* as a result of the *qualifying event*; or
- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan*'s *summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan*'s procedures for providing such notice to the *Plan Administrator*.

In any event, this notice must be furnished before the end of the first 18 months of *COBRA continuation coverage*.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

- The date of the final determination by the SSA that the *qualified beneficiary* is no longer disabled; or
- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan*'s *summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan*'s procedures for providing such notice to the *Plan Administrator*.

The notice must be postmarked (if mailed), or received by the *Plan Administrator* (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend *COBRA continuation coverage* is lost, and if you are electing *COBRA continuation coverage*, your coverage under the *Plan* will terminate on the last date for which you are eligible under the terms of the *Plan*, or if you are extending *COBRA continuation coverage*, such coverage will end on the last day of the initial 18-month *COBRA continuation coverage* period.

Who can provide the notice?
Any individual who is the *covered employee* (or former employee), a *qualified beneficiary* with respect to the *qualifying event*, or any representative acting on behalf of the *covered employee* (or former employee) or *qualified beneficiary*, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related *qualified beneficiaries* with respect to the *qualifying event*.

What are the required contents of the notice?
The notice must contain the following information:

- Name and address of the *covered employee* or former employee;
- If you already are receiving *COBRA continuation coverage* and wish to extend the maximum coverage period, identification of the initial *qualifying event* and its date of occurrence;
- A description of the *qualifying event* (for example, divorce, legal separation, cessation of dependent status, entitlement to *Medicare* by the *covered employee* or former employee, death of the *covered employee* or former employee, disability of a *qualified beneficiary* or loss of disability status);
- In the case of a *qualifying event* that is divorce or legal separation, name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
- In the case of a *qualifying event* that is *Medicare* entitlement of the *covered employee* or former employee, date of entitlement, and name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*;
- In the case of a *qualifying event* that is a dependent child's cessation of dependent status under the *Plan*, name and address of the child, reason the child ceased to be an eligible *dependent* (for example, attained limiting age, lost student status, married or other);
- In the case of a *qualifying event* that is the death of the *covered employee* or former employee, the date of death, and name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*;
- In the case of a *qualifying event* that is disability of a *qualified beneficiary*, name and address of the disabled *qualified beneficiary*, name(s) and address(es) of other family members covered under the *Plan*, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
- In the case of a *qualifying event* that is loss of disability status, name and address of the *qualified beneficiary* who is no longer disabled, name(s) and address(es) of other family members covered under the *Plan*, the date the disability ended and the date of the SSA's determination; and
- A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no *COBRA continuation coverage*, or extension of such coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the *Plan Administrator* may request additional information. If the individual fails to provide such information within the time period specified by the *Plan Administrator* in the request, the *Plan Administrator* may reject the notice if it does not contain enough information for the *Plan Administrator* to identify the plan, the *covered employee* (or former employee), the *qualified beneficiaries*, the *qualifying event* or disability, and the date on which the *qualifying event*, if any, occurred.

Electing *COBRA continuation coverage*
Complete instructions on how to elect *COBRA continuation coverage* will be provided by the *Plan Administrator* within 14 days of receiving the notice of your *qualifying event*. You then have 60 days in which to elect *COBRA continuation coverage*. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If *COBRA continuation coverage* is not elected in that 60-day period, then the right to elect it ceases.

Each *qualified beneficiary* will have an independent right to elect *COBRA continuation coverage*. *Covered employee*s may elect *COBRA continuation coverage* on behalf of their spouses, and parents may elect *COBRA continuation coverage* on behalf of their *children*.

In the event that the *Plan Administrator* determines that the individual is not entitled to *COBRA continuation coverage*, the *Plan Administrator* will provide to the individual an explanation as to why he or she is not entitled to *COBRA continuation coverage*.

How long does *COBRA continuation coverage* last?
COBRA continuation coverage will be available up to the maximum time period shown below. Multiple *qualifying event*s which may be combined under *COBRA* will not continue coverage for more than 36 months beyond the date of the original *qualifying event*. When the *qualifying event* is "entitlement to *Medicare*," the 36-month continuation period is measured from the date of the original *qualifying event*. For all other *qualifying event*s, the continuation period is measured from the date of the *qualifying event*, not the date of loss of coverage.

When the *qualifying event* is the death of the *covered employee* (or former employee), the *covered employee*'s (or former employee's) becoming entitled to *Medicare* benefits (under Part A, Part B, or both), your 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 *covered employee*'s hours of employment, and the *covered employee* became entitled to *Medicare* benefits less than 18 months before the *qualifying event*, *COBRA continuation coverage* for *qualified beneficiaries* other than the *covered employee* lasts until 36 months after the date of *Medicare* entitlement. For example, if a *covered employee* becomes entitled to *Medicare* 8 months before the date on which his or her employment terminates, *COBRA continuation coverage* for his or her spouse and children can last up to 36 months after the date of *Medicare* entitlement, which is equal to 28 months after the date of the *qualifying event* (36 months minus 8 months).

Otherwise, when the *qualifying event* is the end of employment (for reasons other than gross misconduct) or reduction of the *covered employee*'s hours of employment, *COBRA continuation coverage* generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of *COBRA continuation coverage* can be extended.

Disability extension of 18-month period of *COBRA continuation coverage*
If you or anyone in your family covered under the *Plan* is determined by the SSA to be disabled and you notify the *Plan Administrator* as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of *COBRA continuation coverage*, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of *COBRA continuation coverage* and must last at least until the end of the 18-month period of *COBRA continuation coverage*.

Second qualifying event extension of 18-month period of *COBRA continuation coverage*
If your family experiences another *qualifying event* while receiving 18 months of *COBRA continuation coverage*, the spouse and *dependent* children in your family can get up to 18 additional months of *COBRA continuation coverage*, for a maximum of 36 months, if notice of the second *qualifying event* properly is given to the *Plan* as set forth above. This extension may be available to the spouse and any *dependent children* receiving *COBRA continuation coverage* if the *covered employee* or former employee dies, becomes entitled to *Medicare* benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the *Plan* as a *dependent child*, 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. An extra fee will be charged for this extended *COBRA continuation coverage*.

Does *COBRA continuation coverage* ever end earlier than the maximum periods above?
COBRA continuation coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your *participating employer* ceases to provide a group health plan to any employee;
- The date on which coverage ceases by reason of the *qualified beneficiary*'s failure to make timely payment of any required premium;
- The date that the *qualified beneficiary* first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either *Medicare* Part A or Part B (whichever comes first); or
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the *qualified beneficiary* is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for *COBRA continuation coverage*
Once *COBRA continuation coverage* is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, *COBRA continuation coverage* will be canceled and will not be reinstated.

Additional Information
Additional information about the *Plan* and *COBRA continuation coverage* is available from the *Plan Administrator*, who is:

Board of Trustees of the United Workers Health Fund Comprehensive Health Plan
50 Charles Lindbergh Blvd., Suite 207
Uniondale, NY 11553
(877)347-7225

Current Addresses
In order to protect your family's rights, you should keep the *Plan Administrator* (who is identified above) informed of any changes in the addresses of family members.

CLAIM PROCEDURES

You will receive a *Plan* identification (ID) card which will contain important information, including claim filing directions and contact information. Your ID card will show your *PPO network*, and your Cost Containment Program administrator.

At the time you receive treatment, show your ID card to your *provider* of service. In most cases, your *provider* will file your claim for you. You may file the claim yourself by submitting the required information to:

Empire Blue Cross and Blue Shield
PO Box 3877
Church St. Station
New York, NY 10008

Most claims under the *Plan* will be *"post service claims."* A *"post service claim"* is a claim for a benefit under the *Plan* after the services have been rendered. *Post service claims* must include the following information in order to be considered filed with the Plan:

A Form HCFA or Form UB92 completed by the *provider* of service, or a form approved for use by the ADA, completed by the dentist, including:

- The date of service;
- The name, address, telephone number and tax identification number of the *provider* of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges (including *PPO network* repricing information);
- The name of the *Plan*;
- The name of the covered *employee*; and
- The name of the patient.

A call from a *provider* who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a *covered expense* before the treatment is rendered, is not a "claim" since an actual claim for benefits is not being filed with the *Plan*. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Procedures For All Claims
The procedures outlined below must be followed by *participants* to obtain payment of health benefits under this *Plan*.

Health Claims
All claims and questions regarding health claims should be directed to the *third party administrator*. The *Plan Administrator* shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with *ERISA*. Benefits under the *Plan* will be paid only if the *Plan Administrator* decides in its discretion that the *participant* is entitled to them. The responsibility to process claims in accordance with the *summary plan description* may be delegated to the *third party administrator*; provided, however, that the *third party administrator* is not a fiduciary of the *Plan* and does not have the authority to make decisions involving the use of discretion.

Each *participant* claiming benefits under the *Plan* shall be responsible for supplying, at such times and in such manner as the *Plan Administrator* in its sole discretion may require, written proof that the expenses were *incurred* or that the benefit is covered under the *Plan*. If the *Plan Administrator* in its sole discretion shall determine that the *participant* has not *incurred* a *covered expense* or that the benefit is not covered under the *Plan*, or if the *participant* shall fail to furnish such proof as is requested, no benefits shall be payable under the *Plan*.

The procedures outlined below must be followed by Participants ("claimants") to obtain payment of health or disability benefits under this *Plan*.

All claims and questions regarding claims should be directed to the Third Party Administrator, which is Dickinson Group. The *Plan Administrator* shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with *ERISA*. Benefits under the *Plan* will be paid only if the *Plan Administrator* decides in its discretion that the claimant is entitled to them.

Each claimant claiming benefits under the *Plan* shall be responsible for supplying, at such times and in such manner as the *Plan Administrator* in its sole discretion may require, written proof that the expenses were incurred or that the benefit or disability is covered under the *Plan*. If the *Plan Administrator* in its sole discretion shall determine that the claimant has not incurred a covered expense or that the benefit or disability is not covered under the *Plan*, or if the claimant shall fail to furnish such proof as is requested, no benefits or further benefits shall be payable under the *Plan*.

Under the *Plan*, there are three types of claims: Pre-service (Non-urgent), Concurrent Care and Post-service.

- *Pre-service Claims*. A *"pre-service claim"* is a claim for a benefit under the *Plan* where the *Plan* conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

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

  It is important to remember that, if a *participant* needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the *Plan* for prior approval. The *participant* should obtain such care without delay.

  Further, if the *Plan* does not require the *participant* to obtain approval of a specific medical service prior to getting treatment, then there is no *pre-service claim.* The *participant* simply follows the *Plan's* procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a *post-service claim.*

- Concurrent Claims. A "Concurrent Claim" arises when the *Plan* has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

  - The *Plan* determines that the course of treatment should be reduced or terminated; or

  - The claimant requests extension of the course of treatment beyond that which the *Plan* has approved.

  Since the *Plan* does not require the *participant* to obtain approval of a medical service in an urgent care situation prior to getting treatment, then there is no need to contact the *Plan Administrator* to request an extension of a course of treatment in an urgent care situation. The *participant* simply follows the *Plan's*

procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a *post-service claim.*

- Post-service Claims. A "Post-service Claim" is a claim for a benefit under the *Plan* after the services have been rendered.

When Claims Must Be Filed
Post-service claims must be filed with Empire within 180 days of the date charges for the service were incurred. Benefits are based upon the *Plan's* provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

- A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by Empire in accordance with the *Plan*'s procedures.

  Upon receipt of the appropriate information, the claim will be deemed to be filed with the *Plan*.

Dickinson Group will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by Empire within 45 days from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions
The *Plan Administrator* shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-service Non-urgent Care Claims.
  - If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the *Plan Administrator* and the claimant (if additional information was requested during the extension period).
- Concurrent Claims.
  - *Plan* Notice of Reduction or Termination. If the *Plan Administrator* is notifying the claimant of a reduction or termination of a course of treatment (other than by *Plan* amendment or termination), before the end of such period of time or number of treatments. The claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
  - Request by Claimant Involving Non-urgent Care. If the *Plan Administrator* receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided

within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

- Post-service Claims.

  - If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the *Plan Administrator* and the claimant.

- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

- Extensions – Post-service Claims. This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the *Plan*.

Notification of an Adverse Benefit Determination
The *Plan Administrator* shall provide a claimant with a notice, either in writing or electronically, with written or electronic notice following within 3 days), containing the following information:

- A reference to the specific portion(s) of the *plan document* and *summary plan description* upon which a denial is based;

- Specific reason(s) for a denial;

- A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

- A description of the *Plan*'s review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of *ERISA* following an adverse benefit determination on final review;

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the *Plan* did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request); and

- In the case of denials based upon a medical judgment (such as whether the treatment is *medically necessary* or *experimental*), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims
In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this *Plan* provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the *Plan* provides:

- Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;

- Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the *Plan*, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;

- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the *Plan* fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the *Plan* in connection with a claim, even if the *Plan* did not rely upon their advice; and

- That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits in possession of the *Plan Administrator* or Dickinson Group; information regarding any voluntary appeals procedures offered by the *Plan*; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the claimant's medical circumstances.

Requirements for Appeal
The claimant must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination.

- To file an appeal in writing, the claimant's appeal must be addressed as follows:

United Workers Health Fund
Dickinson Group, LLC.
50 Charles Lindbergh Blvd., Suite 207
Uniondale, NY 11553

Upon receipt, an appeal shall be deemed to be filed with the *Plan* provided all of the information listed below is included.

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the *Plan*. Any appeal must include:

- The name of the Employee/claimant;
- The Employee/claimant's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the *Plan*.

If the claimant provides all of the required information, it may be that, in the case of a health claim, the expenses will be eligible for payment under the *Plan*, or in the case of a disability claim, the claimant will be eligible for disability benefits under the *Plan*.

Timing of Notification of Benefit Determination on Review
The *Plan Administrator* shall notify the claimant of the *Plan*'s benefit determination on review within the following timeframes:

- Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
- Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim –Pre-service Non-urgent or Post-service.
- Post-service Claims. Within a reasonable period of time, but not later than 60 days after receipt of the appeal.
- Calculating Time Periods. The period of time within which the *Plan*'s determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this *Plan*, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The *Plan Administrator* shall provide a claimant with notification in writing or electronically, of a *Plan*'s adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the *plan document* and *summary plan description* on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the *Plan* did not rely upon their advice;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the claimant's medical circumstances, will be provided free of charge upon request;
- A statement of the claimant's right to bring an action under section 502(a) of *ERISA*, following an adverse benefit determination on final review; and
- The following statement: "You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on review, the *Plan Administrator* shall provide such access to, and copies of, documents, records, and other information described in the third through sixth bulleted item of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review
If, for any reason, the *participant* does not receive a written response to the appeal within the appropriate time period set forth above, the *participant* may assume that the appeal has been denied. Note that: **all claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 180 days after the *Plan's* claim review procedures have been exhausted.**

External Review
When a *participant* has exhausted the internal appeals process outlined above and the claim involves a medical judgment or rescission of coverage, the *participant* has a right to have that decision reviewed by independent health care professionals who has no association with the *Plan*, the *Plan Sponsor*, or the *plan administrator*. If the adverse benefit determination involves a medical judgment or a rescission of coverage, you may submit a request for external review within **4 months** after receipt of a denial of benefits to:

United Workers Health Fund
Dickinson Group, LLC.
50 Charles Lindbergh Blvd.
Suite 207
Uniondale, NY 11530
Attn: Appeal Department

For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of the denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is *experimental* or investigation, you also may be entitled to file a request for external review of our denial.

Please contact Dickinson Group at 877-347-7225 with any questions on your rights to external review.

Appointment of Authorized Representative
A *participant* is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a *participant* to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the *participant* must complete a form which can be obtained from the *Plan Administrator* or the *third party administrator*. However, in connection with a claim involving urgent care, the *Plan* will permit a health care professional with knowledge of the *participant's* medical condition to act as the *participant's* authorized representative without completion of this form. In the event a *participant* designates an authorized representative, all future communications from the *Plan* will be with the representative, rather than the *participant*, unless the *participant* directs the *Plan Administrator*, in writing, to the contrary.

Physical Examinations
The *Plan* reserves the right to have a *physician* of its own choosing examine any *participant* whose *illness* or *injury* is the basis of a claim. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan Administrator* may reasonably require during the pendency of a claim. The *participant* must comply with this requirement as a necessary condition to coverage.

Autopsy
The *Plan* reserves the right to have an autopsy performed upon any deceased *participant* whose *illness* or *injury* is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits
All benefits under this *Plan* are payable, in U.S. Dollars, to the covered *employee* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a claim. In the event of the death or incapacity of a covered *employee* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his or her estate, the *Plan Administrator* may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the *Plan Administrator*, is or was providing the care and support of such *employee*.

Assignments
Benefits for medical expenses covered under this *Plan* may be assigned by a *participant* to the *provider;* however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered *employee* and the assignee, has been received before the proof of loss is submitted.

Non-U.S. Providers
Medical expenses for care, supplies or services which are rendered by a *provider* whose principal place of business or address for payment is located outside the United States (a *"non-U.S. provider"*) are payable under the *Plan*, subject to all *Plan* exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a *non-U.S. provider;*
- The *participant* is responsible for making all payments to *non-U.S. providers*, and submitting receipts to the *Plan* for reimbursement;

- Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date;

- The *non-U.S. provider* shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and

- Claims for benefits must be submitted to the *Plan* in English.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the *Plan's* terms, conditions, limitations or exclusions. Whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the *participant* or *dependent* on whose behalf such payment was made.

A *participant, dependent, provider*, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return the amount of such erroneous payment to the *Plan* within 30 days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a *participant* or other entity does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the *participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the *Plan*, in consideration of such payments, agree to be bound by the terms of this *Plan* and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-9 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator*. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *participant, provider* or other person or entity to enforce the provisions of this section, then that *participant, provider* or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

Medicaid Coverage
A *participant's* eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such *participant.* Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the *participant,* as required by the state Medicaid program; and the *Plan* will honor any subrogation rights the state may have with respect to benefits which are payable under the *Plan*.

COORDINATION OF BENEFITS

Benefits Subject to This Provision
This provision applies to all benefits provided under any section of this *Plan*.

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

- Any responsible third party, its insurer, or any other source on behalf of that party;
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured, or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Worker's compensation or other liability insurance company; or
- Any other source, including but not limited to crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

Vehicle limitation
When medical payments are available under any vehicle insurance, the *Plan* shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This *Plan* shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title, or classification.

"Allowable Expenses"
"*Allowable expenses*" shall mean any *medically necessary*, *usual*, *reasonable and customary* item of expense, at least a portion of which is covered under this *Plan*. When some *other plan* provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be the benefit.

It is important that you fulfill any requirements of *other plan(s)* for payment of benefits. If you fail to properly file for, and receive payment by, any *other plan(s)*, this *Plan* will estimate the benefits that would otherwise have been payable and apply that amount, as though actually paid, to the "Application to Benefit Determination" calculation explained in this section.

In the case of HMO (Health Maintenance Organization) plans, this *Plan* will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the *participant* does not use an HMO provider, this *Plan* will not consider as *allowable expenses* any charge that would have been covered by the HMO had the *participant* used the services of an HMO provider.

Effect on Benefits

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. If this *Plan* is a secondary or subsequent plan, this *Plan* will pay the balance due up to 100% of the total cumulative *allowable expenses* for that calendar year; however, in no event will this *Plan* pay more than it would have in the absence of any *other plan(s)*. When there is a conflict in the order of benefit determination, this *Plan* will never pay more than 50% of *allowable expenses.*

When medical payments are available under automobile insurance, this *Plan* will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the *other plan* will be ignored for the purposes of determining the benefits under this *Plan*. This is the case when:

- The *other plan* would, according to its rules, determine its benefits after the benefits of this *Plan* have been determined; and

- The rules in the section entitled "Order of Benefit Determination" would require this *Plan* to determine its benefits before the *other plan*.

Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are listed below. The *Plan* will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim.

- A plan without a coordinating provision will always be the primary plan;

- The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, will be determined before the benefits of a plan which covers such person as a dependent.

- If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

  - When the parents are separated (whether or not ever legally married) or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or

  - When the parents are separated (whether or not ever legally married) or divorced and, the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

  Notwithstanding the above provisions, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any *other plan* which covers the child as a dependent child; and

- When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

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

Facility of Payment
Whenever payments which should have been made under this *Plan* in accordance with this provision have been made under any *other plans*, the *Plan Administrator* may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this *Plan* and, to the extent of such payments, this *Plan* shall be fully discharged from liability.

Right of Recovery
Whenever payments have been made by this *Plan* with respect to *allowable expenses* in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the *Plan* shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this *Plan*.

Coordination of Benefits with Medicare
If you are eligible for *Medicare*, and you are eligible for coverage under this *Plan*, you may choose to continue coverage under this *Plan*, and any *Medicare* benefits to which you are entitled may be used to supplement the benefits of this *Plan*. If, however, you choose to make *Medicare* your primary plan, you may not supplement your *Medicare* coverage with the benefits of this *Plan*.

In all cases, coordination of benefits with *Medicare* will conform with Federal law. When coordination of benefits with *Medicare* is permitted, each individual who is eligible for *Medicare* will be assumed to have full *Medicare* coverage whether or not the individual has enrolled for full coverage. Your benefits under this *Plan* will be secondary to *Medicare* to the extent allowed by Federal law.

Coordination of Benefits with Medicaid
In all cases, benefits available through a state or Federal Medicaid program will be secondary or subsequent to the benefits of this *Plan*.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Benefits Subject to this Provision
This provision shall apply to all benefits provided under any section of this *Plan*.

When this Provision Applies
A *participant* may *incur* medical or other charges related to *injuries* or *illness* caused by the act or omission of another person; or *another party* may be liable or legally responsible for payment of charges *incurred* in connection with the *injuries* or *illness*. If so, the *participant* may have a claim against that other person or *another party* for payment of the medical or other charges. In that event, the *Plan* will be secondary, not primary, and the *Plan* will be *subrogated* to all rights the *participant* may have against that other person or *another party* and will be entitled to *reimbursement*. In addition, the *Plan* shall have the first lien against any *recovery* to the extent of benefits paid or to be paid and expenses *incurred* by the *Plan* in enforcing this provision. The *Plan's* first lien supercedes any right that the *participant* may have to be "made whole." In other words, the *Plan* is entitled to the right of first *reimbursement* out of any *recovery* the *participant* procures or may be entitled to procure regardless of whether the *participant* has received compensation for any of his or her damages or expenses, including any of his or her attorneys' fees or costs. Additionally, the *Plan's* right of first *reimbursement* will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the *Plan*, the *participant* agrees that acceptance of benefits is constructive notice of this provision.

The *participant* must:

- Execute and deliver a subrogation and reimbursement agreement;

- Authorize the *Plan* to sue, compromise and settle in the *participant's* name to the extent of the amount of medical or other benefits paid for the *injuries* or *illness* under the *Plan* and the expenses *incurred* by the *Plan* in collecting this amount, and assign to the *Plan* the *participant's* rights to *recovery* when this provision applies;

- Immediately reimburse the *Plan*, out of any *recovery* made from *another party*, 100% of the amount of medical or other benefits paid for the *injuries* or *illness* under the *Plan* and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) *incurred* by the *Plan* in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

- Notify the *Plan* in writing of any proposed settlement and obtain the *Plan's* written consent before signing any release or agreeing to any settlement; and

- Cooperate fully with the *Plan* in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the *Plan*.

When a right of recovery exists, and as a condition to any payment by the *Plan* (including payment of future benefits for other *illnesses* or *injuries*), the *participant* will execute and deliver all required instruments and papers, including a subrogation and reimbursement agreement provided by the *Plan*, as well as doing and providing whatever else is needed, to secure the *Plan's* rights of *subrogation* and *reimbursement*, before any medical or other benefits will be paid by the *Plan* for the *injuries* or *illness*. The *Plan Administrator* may determine, in its sole discretion, that it is in the *Plan's* best interests to pay medical or other benefits for the *injuries* or *illness* before these papers are signed and things are done (for example, to obtain a prompt payment discount); however, in that event, the *Plan* still will be entitled to *subrogation* and *reimbursement*. In addition, the *participant* will do nothing to prejudice the *Plan's* right to *subrogation* and *reimbursement* and acknowledges that the *Plan* precludes operation of the made-whole and common-fund doctrines. A *participant* who receives any *recovery* (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the *recovery* to the *Plan* under the terms of this provision. A *participant* who receives any such *recovery* and does not

immediately tender the *recovery* to the *Plan* will be deemed to hold the *recovery* in constructive trust for the *Plan*, because the *participant* is not the rightful owner of the *recovery* and should not be in possession of the *recovery* until the *Plan* has been fully reimbursed.

The *Plan Administrator* has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement
Any amounts recovered will be subject to *subrogation* or *reimbursement*. In no case will the amount subject to *subrogation* or *reimbursement* exceed the amount of medical or other benefits paid for the *injuries* or *illness* under the *Plan* and the expenses *incurred* by the *Plan* in collecting this amount. The *Plan* has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the *participant* does not receive full compensation for all of his or her charges and expenses.

When *Recovery* Includes the Cost of Past or Future Expenses
In certain circumstances, a *participant* may receive a *recovery* that includes amounts intended to be compensation for past and/or future expenses for treatment of the *illness* or *injury* that is the subject of the *recovery*. This *Plan* will not cover any expenses for which compensation was provided through a previous *recovery*. This exclusion will apply to the full extent of such *recovery* or the amount of the expenses submitted to the *Plan* for payment, whichever is less. The *Plan* also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the *participant* to inform the *Plan Administrator* when expenses are related to an *illness* or *injury* for which a *recovery* has been made. Acceptance of benefits under this *Plan* for which the *participant* has received a *recovery* will be considered fraud, and the *participant* will be subject to any sanctions determined by the *Plan Administrator,* in its sole discretion, to be appropriate. The *participant* is required to submit full and complete documentation of any such *recovery* in order for the *Plan* to consider eligible expenses that exceed the *recovery.*

"Another Party"
"A*nother party*" shall mean any individual or entity, other than the *Plan*, who is liable or legally responsible to pay expenses, compensation or damages in connection with a *participant's injuries* or *illness*.

"*Another party*" shall include the party or parties who caused the *injuries* or *illness*; the insurer, guarantor or other indemnifier of the party or parties who caused the *injuries* or *illness*; a *participant's* own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is liable or legally responsible for payment in connection with the *injuries* or *illness*.

"Recovery"
"*Recovery*" shall mean any and all monies paid to the *participant* by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the *injuries* or *illness*. Any *recovery* shall be deemed to apply, first, for *reimbursement*.

"Subrogation"
"*Subrogation*" shall mean the *Plan's* right to pursue the *participant's* claims for medical or other charges paid by the *Plan* against *another party*.

"Reimbursement"
"*Reimbursement*" shall mean repayment to the *Plan* for medical or other benefits that it has paid toward care and treatment of the *injury* or *illness* and for the expenses incurred by the *Plan* in collecting this benefit amount.

When a *Participant* retains an Attorney
If the *participant* retains an attorney, that attorney must sign the subrogation and reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other *illnesses* or *injuries*. Additionally, the *participant's* attorney must recognize and consent to the fact that the *Plan* precludes the

operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his or her pursuit of *recovery*. The *Plan* will not pay the *participant's* attorneys' fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the *participant's* attorneys' fees and costs. Attorneys' fees will be payable from the *recovery* only after the *Plan* has received full *reimbursement*.

An attorney who receives any *recovery* (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the *recovery* to the *Plan* under the terms of this provision. A *participant's* attorney who receives any such *recovery* and does not immediately tender the *recovery* to the *Plan* will be deemed to hold the *recovery* in constructive trust for the *Plan*, because neither the *participant* nor his or her attorney is the rightful owner of the *recovery* and should not be in possession of the *recovery* until the *Plan* has been fully reimbursed.

When the *Participant* is a Minor or is Deceased
The provisions of this section apply to the parents, trustee, guardian or other representative of a minor *participant* and to the heir or personal representative of the estate of a deceased *participant*, regardless of applicable law and whether or not the representative has access or control of the *recovery*.

When a *Participant* Does Not Comply
When a *participant* does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the *participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as *reimbursement* to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required *reimbursement*. If the *Plan* must bring an action against a *participant* to enforce the provisions of this section, then that *participant* agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

DEFINITIONS

In this section you will find the definitions for the italicized words found throughout this *summary plan description*. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the *Plan*; please refer to the appropriate sections of this *summary plan description* for that information.**

"*Accident*" means a sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

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

"*ADA*" means the American Dental Association**.**

"*AHA*" means the American Hospital Association.

"*AMA*" means the American Medical Association.

"*Ambulatory surgical center*" means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of *physicians*, with permanent facilities that are equipped and operated primarily for the purpose of performing *surgical procedures*, with continuous *physician* services and registered professional nursing service whenever a patient is in the *institution*, and which does not provide service or other accommodations for patients to stay overnight.

"*Birthing center*" means an independent, licensed facility which is certified under the statutory requirements of the given state in which it is located, and provides 24 hour nursing services by registered graduate nurses and certified nurse midwives. An obstetrician or a *physician* qualified to practice obstetrics with *hospital* admitting privileges must be available for consultation and referral and on call during labor and delivery. A birthing center must be equipped, staffed, and operating for the purpose of providing:

- Family centered obstetrical care for patients during uncomplicated *pregnancy*, delivery, and immediate postpartum periods;
- Care for infants born in the center who are either normal or who have abnormalities which do not impair functions or threaten life; and
- Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

A birthing center must have an agreement with an ambulance service and a *hospital* to accept transfer.

"*Brand name drug*" means drugs produced and marketed exclusively by a particular manufacturer. These names are usually registered as trademarks with the Patent Office and confer upon the registrant certain legal rights with respect to their use.

"*Business associate*" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103.

"*Cardiac care unit*" means a separate, clearly designated service area which is maintained within a *hospital* and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;

- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the *hospital*;

- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;

- It contains at least two beds for the accommodation of critically ill patients; and

- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

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

"Child(ren)" means, in addition to the *employee's* own blood descendant of the first degree or lawfully adopted child, a child placed with the *employee* in anticipation of adoption, a child who is an *alternate recipient* under a QMCSO as required by the federal Omnibus Budget Reconciliation Act of 1993, any stepchild or any other child for whom the *employee* has obtained legal guardianship.

"Chiropractic care" means or all services related to a chiropractic visit.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Complications of pregnancy" means:

- Conditions whose diagnoses are distinct from *pregnancy*, but adversely affected by *pregnancy* or caused by *pregnancy*. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, and eclampsia;

- A non-elective cesarean section *surgical procedure*; or

- A terminated ectopic *pregnancy*.

Complications of pregnancy does not mean:

- False labor;

- Occasional spotting;

- Prescribed rest during the period of *pregnancy*; or

- Similar conditions associated with the management of a difficult *pregnancy*, but not constituting a distinct complication of *pregnancy*.

"Cosmetic" or ***"cosmetic surgery"*** means any *surgery*, service, *drug* or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an *injury*.

"Covered entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103.

"Covered expense" means a *medically necessary* service or supply which is listed for coverage in this *Plan.*

"Custodial care" means care or confinement provided primarily for the maintenance of the *participant*, essentially designed to assist the participant, whether or not *totally disabled*, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

"Deductible" means an amount of money that must be paid by a *participant* for *covered expenses* before the *Plan* will reimburse additional *covered expenses incurred* during that *plan year.*

"Dentally necessary" means services or supplies, which are determined by the *Plan Administrator* to be:

- Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the dental condition, *injury* or *illness*;
- Provided for the diagnosis or direct care and treatment of the dental condition, *injury* or *illness*;
- Within standards of good dental practice within the organized dental community;
- Not primarily for the convenience of the *participant*, the *participant's dentist* or another *provider*; and
- The most appropriate supply or level of service which can safely be provided.

"Dentist" means an individual holding a D.D.S. or D.M.D. degree, who is licensed to practice dentistry in the jurisdiction where such services are provided.

"Dependent" means one or more of the following person(s):

- An e*mployee*'s lawfully married spouse possessing a marriage license who is not divorced from the e*mployee*. For purposes of this section, "marriage or married" means a union that is legally recognized as a marriage under the state law where such marriage was performed;
- An e*mployee*'s *child* who is less than 26 years of age; or
- An e*mployee*'s *child*, regardless of age, who was continuously covered prior to attaining the limiting age under the bullets above, who is mentally or physically incapable of sustaining his or her own living. Such *child* must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the *Plan* must be furnished and approved by the *Plan* within 31 days after the date the *child* attains the limiting age under the bullets above. The *Plan* may require, at reasonable intervals, subsequent proof satisfactory to the *Plan* during the next two years after such date. After such two-year period, the *Plan* may require such proof, but not more often than once each year.

"*Dependent*" does not include any person who is a member of the armed forces of any country or who is a resident of a country outside the United States.

The *Plan* reserves the right to require documentation, satisfactory to the *Plan Administrator*, which establishes a *dependent* relationship.

"Diagnostic service" means a test or procedure performed for specified symptoms to detect or to monitor an *illness* or *injury*. It must be ordered by a *physician* or other professional *provider*.

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

"Durable medical equipment" means equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of an *illness* or *injury*; and
- Is appropriate for use in the home.

"Effective date" means, November 1, 2004, the original *effective date* of the *Plan*.

"Emergency" means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, hemorrhage, severe chest pain, difficulty in breathing, sudden onset of weakness or paralysis of a body part, severe burns, unconsciousness, partial or complete severing of a limb, and convulsions.

Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the *Plan*, that an *emergency* did exist.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (i), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

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

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

"Employee" means a person who is employed by an Employer who is required, pursuant to a collective bargaining agreement, to make contributions to the Fund on your behalf.

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

"Essential health benefits" shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within

the categories: ambulatory patient services; *emergency services*; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

"Experimental" means services, supplies, care, procedures, treatments or courses of treatment, which:

- Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

- Are rendered on a research basis as determined by the United States Food and Drug Administration and the *AMA*'s Council on Medical Specialty Societies. All phases of clinical trials shall be considered experimental.

- *Drugs* are considered *experimental* if they are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

"Family unit" means the *employee*, his or her spouse and his or her *dependent children*.

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

"FMLA leave" means a *leave of absence*, which the *company* is required to extend to an *employee* under the provisions of the *FMLA*.

"Generic drug" means drugs not protected by a trademark, usually descriptive of drug's chemical structure.

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

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

- Such individual's genetic tests;

- The genetic tests of family members of such individual; and

- The manifestation of a disease or disorder in family members of such individual.

The term "*genetic information*" includes participating in clinical research involving genetic services.

Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes.

Therefore, this *Plan* will not discriminate in any manner with its *participants* on the basis of such genetic information.

"Health Breach Notification Rule" shall mean 16 CFR Part 318.

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

"HIPAA rules" means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Home health care" means certain services and supplies required for treatment of an *illness* or *injury* in the *participant's* home as part of a formal treatment plan certified by the attending *physician* and approved by the *Plan Administrator*.

"Home health care agency" means an agency or organization which provides a program of *home health care* and which:

- Is approved as a home health agency under *Medicare*;
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
- Meets all of the following requirements:
  - It is an agency which holds itself forth to the public as having the primary purpose of providing a *home health care* delivery system bringing supportive services to the home;
  - It has a full-time administrator;
  - It maintains written records of services provided to the patient;
  - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
  - Its employees are bonded and it provides malpractice insurance.

"Hospice Care Agency" means an agency which has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of the following requirements:

- Has obtained any required certificate of need;
- Provides 24 hour a day, seven days a week service, supervised by a qualified practitioner;
- Has a full-time coordinator;
- Keeps written records of services provided to each patient;
- Has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and
- Has a licensed social service coordinator.

A Hospice Care Agency will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area medical personnel to use its services for their patients and use volunteers trained in care of and services for non-medical needs.

"Hospital" means an *institution* that meets all of the following requirements:

- It provides medical and *surgical* facilities for the treatment and care of injured or sick persons on an *inpatient* basis;

- It is under the supervision of a staff of *physicians*;
- It provides 24-hour-a-day nursing service by registered nurses;
- It is duly licensed as a *hospital*, except that this requirement will not apply in the case of a state tax-supported *institution*;
- It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type institution, or an institution which is supported in whole or in part by a federal government fund; and
- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the *AMA* and the *AHA*.

The requirement of *surgical* facilities shall not apply to a *hospital* specializing in the care and treatment of mentally ill patients, provided such *institution* is accredited as such an *institution* by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the *AMA* and the *AHA*.

"Illness" means a condition, sickness or disease not resulting from trauma.

"Immediate relative" means spouse, child, brother, sister or parent of the *participant*, whether by birth, adoption or marriage

"Impregnation and infertility treatment" means artificial insemination, fertility *drugs*, G.I.F.T. (Gamete Intrafallopian Transfer), impotency *drugs* such as Viagra™, in-vitro fertilization, sterilization and/or reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure, whether or not such procedure is successful.

"Incurred" means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are *incurred* for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, *covered expenses* for the entire procedure or course of treatment are not *incurred* upon commencement of the first stage of the procedure or course of treatment.

"Injury" means physical damage to the body, caused by an external force, and which is due directly and independently of all other causes, to an *accident*.

"Inpatient" means any person who, while confined to a *hospital*, is assigned to a bed in any department of the *hospital* other than its outpatient department and for whom a charge for *room and board* is made by the *hospital*.

"Institution" means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community mental health center, residential treatment facility, *psychiatric hospital*, *substance abuse treatment center*, alternative birthing center, *home health care* center, or any other such facility that the *Plan* approves.

"Intensive care unit" means a separate, clearly designated service area which is maintained within a *hospital* and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the *hospital*;

- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;

- It contains at least two beds for the accommodation of critically ill patients; and

- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

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

"Mastectomy" means the *surgical* removal of all or part of a breast.

"Medically necessary" means services or supplies which are determined by the *Plan Administrator* to be:

- Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical condition, *injury* or *illness*;

- Provided for the diagnosis or direct care and treatment of the medical condition, *injury* or *illness*;

- Within standards of good medical practice within the organized medical community;

- Not primarily for the convenience of the *participant*, the *participant's physician* or another *provider*; and

- The most appropriate supply or level of service which can safely be provided.

For *hospital* stays, this means that acute care as an *inpatient* is necessary due to the kind of services the *participant* is receiving or the severity of the *participant's* condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a *physician* does not mean that it is "*medically necessary*." In addition, the fact that certain services are excluded from coverage under this *Plan* because they are not "*medically necessary*" does not mean that any other services are deemed to be "*medically necessary*."

"Medicare" means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

"Mental or nervous disorder" means any *illness* or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services; or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

"Morbid obesity" means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the *participant*.

"Network" means the *Preferred Provider Organization (PPO)* network of *providers* offering discounted fees for services and supplies to *participants*. The *network* will be identified on the *participant's Plan* Identification Card.

"Out-of-pocket expense" means the cost to the *participant* for *deductibles*, coinsurance, copayments, penalties and non-*covered expenses.*

"Participant" means a covered *employee* and his or her covered *dependents* who are eligible for benefits under the *Plan*.

"Participating employer(s)" means the Employers who are covered under collective bargaining or participation agreements with the Fund.

"PHI" shall mean Protected Health Information, as enacted pursuant to *HIPAA.*

"Physician" means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental *Surgery* (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.).

"Plan" means the The United Workers Health Fund Comprehensive Health Plan.

"Plan Administrator" means the Board of Trustees of the United Workers Health Fund Comprehensive Health Plan

"Plan Document" means this *plan document* and *summary plan description*.

"Plan Sponsor" means the Board of Trustees of the United Workers Health Fund Comprehensive Health Plan

"Plan year" means the period commencing January 1 and continuing until the next succeeding anniversary.

"Pre-admission tests" means those *diagnostic services* done before a scheduled *hospital inpatient* admission, provided that:

- The tests are required by the *hospital* and approved by the *physician*;
- The tests are performed on an outpatient basis prior to *hospital* admission;
- The tests are not duplicated on admission to the *hospital*; and
- The tests are performed at the *hospital* where the confinement is scheduled, or at a qualified facility approved by the *hospital* to perform the tests.

"Preferred Provider Organization" or ***"PPO"*** means the network of *providers* offering discounted fees for services and supplies to *participants*. The *network* will be identified on the *participant's Plan* Identification Card.

"Pregnancy" means childbirth and conditions associated with *pregnancy*, including *complications of pregnancy*. *Pregnancy* for covered *employees* and covered spouses will be covered benefits, however, *pregnancy* of a *dependent child* is limited to only the expenses of the mother, not the newborn *child*.

*"**Privacy Standards"*** means the standards for privacy of individually identifiable health information, as enacted pursuant to *HIPAA*.

"Provider" means a *physician*, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, psychiatrist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, certified midwife, or other practitioner or facility defined or listed herein, or approved by the *Plan Administrator*.

*"**Rehabilitation hospital"*** means an *institution* which mainly provides therapeutic and restorative services to sick or injured people. It is recognized as such if:

- It carries out its stated purpose under all relevant federal, state and local laws;
- It is accredited for its stated purpose by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation for Rehabilitation Facilities; or
- It is approved for its stated purpose by *Medicare*.

"Room and board" means an *institution*'s charge for:

- Room and linen service;
- Dietary service, including meals, special diets and nourishment;
- General nursing service; and
- Other conditions of occupancy which are *medically necessary*.

"Security standards" mean the final rule implementing *HIPAA's* Security Standards for the Protection of *Electronic PHI*, as amended.

"Substance abuse" means any use of alcohol, any *drug* (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

"Substance abuse treatment center" means an *institution* which provides a program for the treatment of *substance abuse* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be:

- Affiliated with a *hospital* under a contractual agreement with an established system for patient referral;
- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- Licensed, certified or approved as an alcohol or *substance abuse* treatment program or center by a state agency having legal authority to do so.

"Summary plan description" means this *plan document* and *summary plan description*.

"Surgery" or ***"Surgical Procedure"*** means any of the following:

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

"Third party administrator" means Dickinson Group, LLC.

"Uniformed services" means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps

of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

*"**Waiting period"*** means an interval of time during which the *employee* is in the continuous, *active employment* of his or her *participating employer* before he or she becomes eligible to participate in the *Plan*.

PLAN ADMINISTRATION

Who has the authority to make decisions in connection with the *Plan*?
The *Plan* is administered by the *Plan Administrator* in accordance with *ERISA*. The *Plan Administrator* has retained the services of the *Third Party Administrator* to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* will appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* will administer this *Plan* in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* will have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are *experimental*), to decide disputes which may arise relative to a *participant's* rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* as to the facts related to any claim for benefits and the meaning and intent of any provision of the *Plan*, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrator* decides, in its discretion, that the *participant* is entitled to them.

The duties of the *Plan Administrator* include the following:

- To administer the *Plan* in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the *Plan*;
- To interpret the *Plan*, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a *participant's* rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the *Plan* documents and all other records pertaining to the *Plan*;
- To appoint and supervise a third party administrator to pay claims;
- To perform all necessary reporting as required by *ERISA*;
- To establish and communicate procedures to determine whether *MCSOs and NMSNs* are *QMCSOs*;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the *Plan*'s administration.

May changes be made to the *Plan*?
The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, the *Plan Sponsor* may, in its sole discretion, at any time, amend, suspend or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan*.

Any such amendment, suspension or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required by *ERISA*. In the event that the *Plan Sponsor* is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the *Plan* is terminated, the rights of *participants* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

MISCELLANEOUS INFORMATION

Who pays the cost of the *Plan*?
The *Plan Sponsor* is responsible for funding the *Plan* and will do so as required by law. To the extent permitted by law, the *Plan Sponsor* is free to determine the manner and means of funding the *Plan*. The amount of the *participant's* contribution (if any) will be determined from time to time by the *Plan Sponsor*, in its sole discretion.

Will the *Plan* release my information to anyone?
For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *participant* for benefits under this *Plan*. In so acting, the *Plan Administrator* shall be free from any liability that may arise with regard to such action; however, the *Plan Administrator* at all times will comply with the *privacy standards.* Any *participant* claiming benefits under this *Plan* shall furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

What if the *Plan* makes an error?
Clerical errors made on the records of the *Plan* and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this *Plan* regardless of whether any contributions with respect to *participants* have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

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

What constitutes a fraudulent claim?
The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this *Plan* for the entire *family unit* of which you are a member:

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

Rescission
This *Plan* will rescind coverage only due to fraud or an intentional misrepresentation of a material act. Rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect or the cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premiums or costs of coverage.

How will this document be interpreted?
The use of masculine pronouns in this *summary plan description* shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this *summary plan description* are used for convenience of reference only. *Participants* are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this *summary plan description* applies to eligible or covered *employees* and, where appropriate in context, their covered *dependents*.

How may a *Plan* provision be waived?
No term, condition or provision of this *Plan* shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this *Plan*, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Is this summary plan description a contract between the participating employer and participants?
This *summary plan description* and any amendments constitute the terms and provisions of coverage under this *Plan*. The *summary plan description* shall not be deemed to constitute a contract of any type between the *employer* and any *participant* or to be consideration for, or an inducement or condition of, the employment of any *employee*. Nothing in this *summary plan description* shall be deemed to give any *employee* the right to be retained in the service of the *employer* or to interfere with the right of the *employer* to discharge any *employee* at any time.

What if there is coverage through workers' compensation?
This *Plan* excludes coverage for any i*njury* or *illness* that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such *injury* or *illness*. However, if benefits are paid by the *Plan* and it is later determined that you received or are eligible to receive workers' compensation coverage for the same *injury* or *illness*, the *Plan* is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the *injury* or *illness* regardless of the amount or terms of any settlement you receive from workers' compensation. The *Plan* will exercise its right to recover against you. The *Plan* reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that the *injury* or *illness* was sustained in the course of or resulted from your employment;
- The amount of workers' compensation benefits due specifically to health care expense is not agreed upon or defined by you or the workers' compensation carrier; or
- The health care expense is specifically excluded from the workers' compensation settlement or compromise.

You are required to notify the *Plan Administrator* immediately when you file a claim for coverage under workers' compensation if a claim for the same *injury* or *illness* is or has been filed with this *Plan*. Failure to do so, or to reimburse the *Plan* for any expenses it has paid for which coverage is available through workers' compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the *Plan* for recovery and disciplinary action.

Will the *Plan* cover an alternate course of treatment?
The *Plan Administrator* may, in its sole discretion, determine that a service or supply, not otherwise listed for coverage under this *Plan*, be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply. Such payments will be considered as being in accordance with the terms of this *summary plan description*.

If a *participant*, in cooperation with his or her *provider*, elect a course of treatment that is deemed by the *Plan Administrator*, in its sole discretion, to be more extensive or costly than is necessary to satisfactorily treat the *illness* or *injury*, this *Plan* will allow coverage for the value of the less costly or extensive course of treatment.

HIPAA PRIVACY PRACTICES

The following is a description of certain uses and disclosures that may be made by the *Plan* of your health information:

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with *HIPAA's* Standards for Privacy of Individually Identifiable Health Information (the *"privacy standards"*), the *Plan* may disclose *summary health information* to the *Plan Sponsor,* if the *Plan Sponsor* requests the *summary health information* for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this *Plan;* or
- Modifying, amending or terminating the *Plan*.

The *Plan* is prohibited from using or disclosing genetic information for underwriting purposes, such as determining eligibility or determination of benefits, computation of premium or contribution amounts, application of pre-existing exclusions and other activities related to the creation, replacement, or renewal of a contract of health insurance or health benefits.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the *Plan,* but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information *("PHI")* to the *Plan Sponsor* for *Plan Administration* Purposes
In order that the *Plan Sponsor* may receive and use *PHI* for *plan administration* purposes, the *Plan Sponsor* agrees to:

- Not use or further disclose *PHI* other than as permitted or required by the *Plan* documents or as required by law (as defined in the *privacy standards*);
- Ensure that any agents, including a subcontractor, to whom the *Plan Sponsor* provides *PHI* received from the *Plan* agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to such *PHI*;
- Not use or disclose *PHI* for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *Plan Sponsor,* except pursuant to an authorization which meets the requirements of the *privacy standards;*
- Notify *participants* of any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318);
- Notify the Federal Trade Commission of any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318);
- Report to the *Plan* any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor* becomes aware;
- Make available *PHI* in accordance with section 164.524 of the *privacy standards* (45 CFR 164.524);
- Make available *PHI* for amendment and incorporate any amendments to *PHI* in accordance with section 164.526 of the *privacy standards* (45 CFR 164.526);

- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the *privacy standards* (45 CFR 164.528);

- Make its internal practices, books and records relating to the use and disclosure of *PHI* received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services *("HHS"),* or any other officer or employee of *HHS* to whom the authority involved has been delegated, for purposes of determining compliance by the *Plan* with part 164, subpart E, of the *privacy standards* (45 CFR 164.500 *et seq*);

- Obtain authorization prior to the sale of any *PHI*;

- If feasible, return or destroy all *PHI* received from the *Plan* that the *Plan Sponsor* still maintains in any form and retain no copies of such *PHI* when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the *PHI* infeasible; and

- Ensure that adequate separation between the *Plan* and the *Plan Sponsor,* as required in section 164.504(f)(2)(iii) of the *privacy standards* (45 CFR 164.504(f)(2)(iii)), is established as follows:

  - The following employees, or classes of employees, or other persons under control of the *Plan Sponsor,* shall be given access to the *PHI* to be disclosed:

    Third Party Claim Administrator
    Board of Trustees of United Workers Comprehensive Health Plan

  - The access to and use of *PHI* by the individuals described above shall be restricted to the *plan administration* functions that the *Plan Sponsor* performs for the *Plan*.

  - In the event any of the individuals described in above do not comply with the provisions of the *Plan* documents relating to use and disclosure of *PHI,* the *Plan Administrator* shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the *Plan* or solicit bids from prospective issuers. *"Plan administration"* functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The *Plan* shall disclose *PHI* to the *Plan Sponsor* only upon receipt of a certification by the *Plan Sponsor* that:

- The *Plan* documents have been amended to incorporate the above provisions; and

- The *Plan Sponsor* agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the *Plan Sponsor*
Pursuant to section 164.504(f)(1)(iii) of the *privacy standards* (45 CFR 164.504(f)(1)(iii)), the *Plan* may disclose to the *Plan Sponsor* information on whether an individual is participating in the *Plan* or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the *Plan* to the *Plan Sponsor*.

Disclosure of *PHI* to Obtain Stop-loss or Excess Loss Coverage
The *Plan Sponsor* hereby authorizes and directs the *Plan*, through the *Plan Administrator* or the *third party administrator*, to disclose *PHI* to stop-loss carriers, excess loss carriers or managing general underwriters *("MGUs")* for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the *Plan*. Such disclosures shall be made in accordance with the *privacy standards.*

Other Disclosures and Uses of *PHI*
With respect to all other uses and disclosures of *PHI*, the *Plan* shall comply with the *privacy standards.*

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the *Plan Sponsor* for Plan Administration Functions

To enable the *Plan Sponsor* to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the *Plan Sponsor* agrees to:

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the *Plan*;

- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

- Ensure that any agent, including a subcontractor, to whom the *Plan Sponsor* provides Electronic PHI created, received, maintained, or transmitted on behalf of the *Plan*, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI;

- Report to the *Plan* any Security Incident of which it becomes aware;

- Notify *participants* of any *PHI* Security Incident of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318); and

- Notify the Federal Trade Commission of any *PHI* Security Incident of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318).

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

STATEMENT OF *ERISA* RIGHTS

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

Receive Information About Your *Plan* and Benefits
Examine, without charge, at the *Plan Administrator*'s office and at other specified locations, such as worksites, all documents governing the *Plan*, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) filed by the *Plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or *dependents* if there is a loss of coverage under the *Plan* as a result of a *qualifying event*. You or your *dependents* may have to pay for such coverage. Review this *summary plan description* and the documents governing the *Plan* on the rules governing your *COBRA* continuation coverage rights.

You should be provided a *certificate of coverage*, free of charge, from your group health plan or health insurance issuer on request or 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.

Prudent Actions by *Plan* Fiduciaries
In addition to creating rights for *participants*, *ERISA* imposes duties upon the people who are responsible for the operation of the *Plan*. The people who operate your *Plan*, called "fiduciaries" of the *Plan*, have a duty to do so prudently and in the interest of you and other *participants* and beneficiaries. No one, including your *participating 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 welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of *Plan* documents or the latest annual report from the *Plan* and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator*. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the *Plan*'s decision or lack thereof concerning the qualified status of a domestic relations order, a *medical child support order* or a *national medical support notice*, you may file suit in 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 would 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 the *Plan*, you should contact the *Plan Administrator*. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the *Plan Administrator*, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, 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.