WESTERN PENNSYLVANIA ELECTRICAL EMPLOYEES INSURANCE TRUST FUND

NON-BARGAINING EMPLOYEES PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

NOVEMBER 2019

CONTENTS

Section 1 THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

This is the Plan Document and Summary Plan Description for the Western Pennsylvania Electrical Employees Insurance Trust Fund ("Fund") as it applies to Non-Bargaining Employees. A separate document explains the Fund as it applies to Bargaining Employees. Together, these documents make up the plan document and summary plan description for the Fund. This document explains the benefits available to you under the Fund as of June 1, 2019. The benefit programs offered under the Fund include the following:

Death Benefit
Hospitalization Program
Medical/Surgical Program
Major Medical Expense Program
Aetna-Meritain Health PPO
Dental Program
Optical Program
Retail and Mail-Service Prescription Drug Program
Member Assistance Program

STATEMENT OF GRANDFATHERED STATUS:

The Board of Trustees believes this Fund is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Fund may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Section 2 GENERAL ADMINISTRATIVE INFORMATION

2-1 Name of Plan
Western Pennsylvania Electrical Employees Insurance Trust Fund (referred to herein as the "Fund")

2-2 Name and Address of Plan Sponsor
Board of Trustees
Western Pennsylvania Electrical Employees Insurance Trust Fund

Union Trustees:	Employer Trustees:
Michael R. Dunleavy IBEW Local Union No. 5 5 Hot Metal Street, Suite 400 Pittsburgh, PA 15203	James J. Ferry Ferry Electric Company 250 Curry Hollow Road, Suite 100 Pittsburgh, PA 15236
Thomas R. McIntyre IBEW Local Union No. 5 5 Hot Metal Street, Suite 400 Pittsburgh, PA 15203	Joseph T. Rios TJR Enterprises, Inc. 431 Butler Street Pittsburgh, PA 15223
Michael W. Varholla IBEW Local Union No. 5 5 Hot Metal Street, Suite 400 Pittsburgh, PA 15203	Todd A. Mikec Lighthouse Electric 1957 Route 519 Canonsburg, PA 15317

The address for the Board of Trustees is: Board of Trustees of the Western Pennsylvania Electrical Employees Insurance Trust Fund, 5 Hot Metal Street, Suite 200, Pittsburgh, PA 15203; 1-877-782-1817.

2-3 Sponsor's Identification Number
The Employer Identification Number issued to the Board of Trustees is 25-6032106.

2-4 Plan Number
501

2-5 Type of Plan
Welfare plan providing death benefits, hospitalization benefits, medical/surgical benefits, major medical benefits, dental benefits, optical benefits, PPO benefits, retail and mail order prescription drug benefits.

2-6 Plan Administrator
Board of Trustees
Western Pennsylvania Electrical Employees Insurance Trust Fund
5 Hot Metal Street, Suite 200
Pittsburgh, PA 15203
1-877-782-1817

The Board of Trustees ("Trustees") has all powers necessary to carry out the provisions of the Fund. The Trustees have the exclusive rights (except as to review of initial claims and first level mandatory claim appeals under the Hospitalization program) and absolute discretion to interpret and apply all terms of the Fund, and may correct any defect, supply any omission, or reconcile any inconsistency or ambiguity in such manner as the Trustees deem advisable.

The Trustees have full authority and absolute discretion to make all factual and/or legal determinations concerning eligibility and status of any person as participants, the right of any person(s) to benefits and all other rights under the Fund, and all other matters concerning plan administration, operation, and interpretation.

The Trustees may make and enforce such administrative rules and regulations of general application as the Trustees may deem necessary or desirable for the efficient administration of the Fund.

2-7 Third Party Administrators

(1) **Central Data Services,** also referred to in this document as the **Fund Office**, 5 Hot Metal Street, Suite 200, Pittsburgh, PA 15203; 1-877-782-1817. Administers COBRA eligibility for all benefits and performs claims administration services for the following benefits:

Medical/Surgical Program
Major Medical Expense Program
Dental Program
Optical Program
Aetna-Meritain Health PPO
Death Benefits

(2) **Highmark, Inc.** 120 Fifth Avenue Place Pittsburgh, PA 15222; (1-800-241-5704). Performs claims administration for the Hospitalization Program described in Section 6.

(3) **Giant Eagle Healthcare Inc.,** 101 Kappa Drive, Pittsburgh, PA 15238; (412) 963-6200. Performs claims administration for the Retail and Mail Order Prescription Drug Program described in Section 13.

2-8 Service of Legal Process

Service may be made upon the Board of Trustees. The name and address for service of legal process is: Board of Trustees, Western Pennsylvania Electrical Employees Insurance Trust Fund, 5 Hot Metal Street, Suite200, Pittsburgh, PA 15203; 1-877-782-1817.

Service may also be made on the Fund's Legal Counsel:

Jason Mettley
Meyer Unkovic & Scott LLC
Henry W. Oliver Building
535 Smithfield Street
Suite 1300
Pittsburgh, PA 15222

2-9 Collective Bargaining Agreement

The Fund is maintained pursuant to a Collective Bargaining Agreement between I.B.E.W. Local Union No. 5 and the Western Pennsylvania Chapter, N.E.C.A., Inc. A copy of the Agreement and a complete list of the employers and organizations participating in the Fund may be obtained by participants or beneficiaries upon written request to the Fund Office and is available for inspection.

Also upon written request, the Fund Office will provide you with information as to whether a particular employer or organization participates in the Fund and the address of that employer or organization.

2-10 Cost

Contributions to the Fund are made by participating employers at the rate specified in the Collective Bargaining Agreement between IBEW Local Union No. 5 and said employers, or in a participation agreement between an employer and the Fund.

2-11 Funding

All benefits under the Fund are paid from the W.P.E.E. Insurance Trust Fund.

2-12 Plan Year

January 1 through December 31

2-13 Amendment of the Plan

The Board of Trustees has the right, at any time, from time to time and without consent of any person, to amend, change or modify, in whole or in part, any or all of the provisions of the Fund and associated trust. Amendments to the Fund and its related trust agreement are made by resolution of the Trustees and execution of a written amendment.

2-14 Termination of the Plan

The Fund and associated trust may be terminated at any time by the Board of Trustees. Any such termination is made by resolution of the Trustees.

Section 3 ELIGIBILITY RULES

3-1 Who is Eligible as a Non-Bargaining Unit Employee

Eligible non-bargaining unit employees are employees of employers on whose behalf the employer submits monthly benefit contributions to the Fund under the terms of an agreement with the Fund, and who are not covered by a collective bargaining agreement or otherwise included in a bargaining unit of employees represented by a labor organization.

3-2 Effective Date of Coverage

Fund benefits are effective on the date specified by the employer after the Fund receives a premium payment and enrollment forms from the employer.

3-3 Termination of Coverage

(a) Coverage ends upon any of the following events:

1. When the employer fails to keep current on payment of contributions to the Fund under the terms of the agreement with the Fund on behalf of the non-bargaining unit employee(s);

2. In the event that the employer fails to keep current on payment of contributions and deductions to the Fund for its bargaining unit employees represented by I.B.E.W. Local Union 5;

3. The employer's cessation of business operations; or

4. When the employee is no longer employed by the employer.

(b) A non-bargaining unit employee and dependents who otherwise meet the Fund's eligibility requirements will not be eligible, notwithstanding any other Fund provision, if the employee and/or any of his dependents does any of the following:

1. Commits fraud with respect to the Fund;

2. Makes a misrepresentation to the Fund administrator, the Trustees or any person or entity which results in the participant or dependent receiving benefits under the Fund to which the participant or dependent would not be entitled in the absence of such misrepresentation;

3. Fails to repay any payment of Fund benefits which the participant and/or his dependent received and were not entitled to receive under the terms of the Fund; and/or

4. Fails to pay any amount which the participant or dependent would be required to pay to the Fund under the subrogation provisions of the Fund.

The Fund may pursue any and all other remedies it might have against the participant or dependents, including but not limited to filing a lawsuit to recover any amounts due to the Fund against the participant or dependents or reducing any benefit payments which might be due to the participant or dependents to recover any amounts due to the Fund.

(c) Upon termination of coverage, under certain circumstances, you may be able to continue coverage under COBRA (See Section 3-11) or, upon application to Highmark you may be able to purchase a direct-pay individual or family private health insurance policy. To get information on Highmark policies, please contact Highmark directly at 1-800-544-6679. Alternatively, you may be able to purchase a health insurance policy through the government's Healthcare Marketplace. To see what is available, visit www.HealthCare.gov.

3-4 Military Leave

Fund health benefits will be provided without charge for the first thirty days of military leave. Thereafter, participants on military leave may continue Fund health benefits by electing COBRA. See Section 3-11 for information about COBRA.

In addition to the right to continue health benefit coverage through COBRA, employees on military leave have certain rights and protections under the Uniformed Services Employment and Reemployment Right Act of 1994 (USERRA) with respect to continuation of health benefit coverage. Rights under COBRA and USERRA are similar, but not identical. For example, COBRA requires that you be permitted to elect to continue coverage for up to an 18-month period, while USERRA permits you to elect to continue coverage for up to a 24-month period.

An election to continue coverage under COBRA will also be considered by the Fund to be an election under USERRA. The law provides the greater rights will apply to your election. **Participants who elect to continue Fund health benefit coverage after the 30th day of the leave are required to pay for the coverage.** Detailed information will be provided at the time of your leave. Participants taking military leave should notify the Fund of the leave as soon as possible.

3-5 Dependent Eligibility

The term "dependents" includes the participant's legal spouse. Only spouses by ceremonial marriage may participate in the Fund. Common-law marriages are not recognized by the Fund.

The term "dependents" also includes children of the participant up to age twenty-six (26).

"Children," as used in this booklet, means (1) blood descendants of the first degree, (2) a legally adopted child (including a child in the custody of the adoptive parents during a period of probation), or (3) a stepchild. Children are covered up through the end of the month of their 26th birth date (Ex: Child's 26th birth date is January 1; cancellation from coverage will be effective January 31).

The Board of Trustees may require such proof as it deems appropriate that the dependent comes within the foregoing definition.

3-6 Termination of Eligibility for Dependents

Eligibility for the spouse and dependent children ends when the participant's eligibility ends.

In addition, in the case of a participant's child, eligibility ceases at the end of the month during which such child fails to meet any of the conditions required for eligibility provided under the "Dependent Eligibility" provisions (Refer to Section 3-5).

In the case of a spouse of the participant, eligibility for benefits will end on the date of the divorce. Eligibility also ends for a spouse when the spouse reaches age 65, except for spouses of active participants.

Please review the entire Section 3 for other events which result in termination of coverage for dependents.

3-7 Change in Family Status

It is important that you give written notice to the Fund of any change in your family status, such as marriage or divorce, birth of a child, or death of any dependent**. Notice of any family status change must be submitted to the Fund Office.**

In the case of marriage, you must submit a copy of the marriage certificate and social security card. In addition, write the birth date of your spouse on the certificate.

In the case of a divorce, you must submit a copy of the divorce decree.

3-8 Special Enrollment Rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

If you decline medical coverage, you must be permitted to add medical coverage if Special Enrollment Rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) apply. In general, these Special Enrollment Rights apply under the following circumstances:

- **<u>Loss of Other Medical Coverage</u>**
  You declined medical coverage for yourself, your spouse or dependent because of other health coverage and the other health coverage is lost. If the other health coverage was COBRA coverage, COBRA has to be exhausted. If the other health coverage was not COBRA, then the coverage must be lost for any of the following reasons: (1) employer contributions terminate; (2) loss of eligibility (including loss of eligibility as a result of legal separation, divorce, cessation of dependent status, termination or reduction in hours of employment or death); (3) the other coverage was an HMO and the individual losing coverage no longer resides, lives or works in the HMO service area and no other medical coverage option is available to the individual; or (4) the other health coverage no longer covers the class of individuals to which the individual belongs. In order to add medical coverage, **you must notify the Fund by no later than 30 days after the termination of the other coverage.**

- **Loss of Coverage Under Medicaid or the State Children's Health Insurance Plan (SCHIP)**
  You declined medical coverage for yourself, your spouse or dependent because of coverage under Medicaid or SCHIP and the other health coverage is lost. In order to add medical coverage, **you must notify the Fund by no later than 60 days after the loss of Medicaid or SCHIP coverage.**

- **You Become Eligible for Premium Assistance Through Medicaid or SCHIP**
  You declined medical coverage for yourself, your spouse or dependent and you later become eligible for premium assistance through Medicaid or SCHIP. In order to add medical coverage, **you must notify the Fund Office by no later than 60 days after becoming eligible for premium assistance through Medicaid or SCHIP.**

- **You Marry or Gain a New Dependent**
  If you marry, then you, your new spouse and any new eligible dependents you acquire as a result of the marriage have the right to enroll in the medical plan. In addition, if you gain a new dependent as a result of birth, adoption or placement for adoption, then you, your spouse and the new child may enroll for medical coverage. Note: In order to make an election change to add medical coverage, **you must notify the Fund by no later than 30 days after the marriage, birth, adoption or placement (as applicable).**

- **You Are Enrolled in "Participant Only" Coverage**
  If you are enrolled in participant only coverage and then marry or acquire a dependent, coverage for your new dependent will become effective on the date you marry or acquire the dependent so long as you are eligible at the time; otherwise your new dependent will be eligible on the date that your eligibility is reinstated.

3-9 Medicare-Eligible Active Participants

If you are age 65 or over and actively employed you receive the same Fund benefits available to participants under age 65. With this:

- The Fund will pay all eligible expenses first; and
- Medicare will then pay for any Medicare eligible expenses not paid by the Fund.

Participants, upon acquiring Medicare (Part A or B), must immediately mail a copy of the Medicare card to the Fund Office.

3-10 Medicare-Eligible Spouses and Dependents of Active Participants

Medicare-eligible spouses of active participants continue to be eligible for Fund benefits.

Medicare-eligible dependents of active participants continue to be eligible for Fund benefits so long as the dependent qualifies as an eligible dependent under the rules of Section 3-5.

Upon acquiring Medicare (Part A or B), a spouse or dependent must immediately mail a copy of the Medicare card to the Fund Office.

3-11 COBRA for Group Health Coverage

COBRA applies to the following group health benefits offered under the Fund. If you elect COBRA you will receive all of the following group health benefits. You will not receive death benefits.

Hospitalization Program
Medical/Surgical Program
Major Medical Program
Aetna-Meritain Health PPO
Dental Program
Optical Program
Retail and Mail Order Drug Program
Member Assistance Program

COBRA requires that most employers or other organizations that sponsor group health plans offer employees and their family members the opportunity to extend their group health plan coverage temporarily at their own expense at group rates if a "qualifying event" causes a loss of coverage. If you choose COBRA coverage, you will be required to pay the entire premium for the coverage plus, possibly, a 2% administrative charge. If COBRA coverage is extended in the event of disability (as explained later), you may be charged up to 150% of the premium.

If you are the **employee** ("covered employee"), you have a right to choose COBRA coverage if you lose group health coverage because of a qualifying event that is a reduction in your hours of employment or the termination of your employment , including retirement (for reasons other than gross misconduct on your part).

The **spouse** of a covered employee has the right to choose COBRA coverage if group health coverage is lost as a result of any of the following four qualifying events:

- A termination of the covered employee's employment including retirement (for reasons other than gross misconduct) or reduction in the covered employee's hours of employment;
- The death of the covered employee;
- Divorce or legal separation from the covered employee; or
- The covered employee becoming enrolled in Medicare (Part A or Part B or both).

A **dependent child** of a covered employee has the right to choose COBRA coverage if group health coverage is lost as a result of any of the following five qualifying events:

- A termination of the covered employee's employment including retirement (for reasons other than gross misconduct) or reduction in the covered employee's hours of employment;
- The death of the covered employee;
- The divorce or legal separation of the covered employee;

- The covered employee becoming enrolled in Medicare (Part A or Part B or both); or
- The dependent ceases to be an eligible dependent under the terms of the group health plan.

In addition, a dependent child born to or adopted by the covered employee during a period of COBRA coverage has the right to choose COBRA coverage. Such a child may be added to COBRA coverage upon written notification to the Fund Office**.**

Each person who is eligible for COBRA coverage is entitled to make a separate election of COBRA coverage. For example, a spouse or dependent child is entitled to elect COBRA coverage even if the covered employee does not make that election. The covered employee or spouse of the covered employee (or person who was the spouse of the covered employee on the day before the qualifying event) may elect COBRA coverage on behalf of other family members who are entitled to elect COBRA coverage with respect to the qualifying event and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

YOU MUST GIVE NOTICE OF A QUALIFYING EVENT IN ORDER TO ELECT COBRA COVERAGE

Under the law, the covered employee, spouse, dependent or personal representative of the employee, spouse or dependent has the responsibility of providing written notice to the Fund Office of a divorce, legal separation, or a child's loss of dependent status under the group health plan. This written notice to the Fund Office must be given within 60 days of the date of any such event. If notice is not given within the 60-day period, the spouse or dependent (as applicable) will not be entitled to COBRA coverage.

The Fund Office determines the covered employee's termination of employment or reduction in hours, death or Medicare enrollment.

When the Fund Office determines that a qualifying event described above has happened, the Fund Office will in turn notify you that you have the right to elect and the procedures for electing COBRA coverage.

Under the law, you have 60 days from the date you are notified of your right to elect COBRA to inform the Fund Office that you want COBRA coverage. **If you do not choose COBRA coverage, your health benefits will end under the plan. You can change a decision you make to reject COBRA coverage any time up until the end of the sixty (60) day election period.**

If you choose COBRA coverage and pay the required premiums, you are required to receive group health coverage which, as of the time coverage is being provided, is identical to the group health coverage provided by the Fund to similarly situated active employees, spouses, or family members. If the group health coverage for similarly situated employees, spouses or family members changes, your coverage will change. In addition, each person who elects COBRA coverage has the same rights with respect to the group health coverage as other covered persons, including any open enrollment, election change and special enrollment rights, as applicable.

Duration of COBRA Coverage

The law requires that you be given the opportunity to maintain COBRA coverage for 36 months from the date coverage ends as a result of the qualifying event unless you lost coverage because of the covered employee's termination of employment or reduction in hours. In that case, the required COBRA coverage period is 18 months from the date you lose coverage as a result of the termination of employment or reduction in hours. However the 18-month coverage period may be extended under the following circumstances.

Disability

If any person entitled to COBRA coverage (the covered employee, spouse or dependent) was disabled (as determined by the Social Security Administration) at any time during the first 60 days of the COBRA coverage period, then all such persons entitled to elect COBRA coverage may be able to continue coverage for up to 29 months, rather than 18 months.

In order to be eligible for the additional 11 months of COBRA coverage, the covered employee, spouse or dependent or personal representative of the covered employee, spouse, or dependent must send written notice to the Fund Office within 60 days after the latest of: (1) the date of the disability determination by the Social Security Administration; (2) the date on which the qualifying event occurred; (3) the date on which you would lose coverage under the Plan as a result of the qualifying event. In addition, the notice must also be provided before the end of the initial 18-month coverage period.

The additional 11 months of coverage provided on account of a disability will end as of the earlier of: (1) the first day of the month beginning more than 30 days after a final determination by the Social Security Administration that the disability no longer exists; or (2) the last day of the 29th month of total coverage. **The covered employee, spouse, dependent or a personal representative of the employee, spouse, or dependent must provide written notice to the Fund Office within 30 days of a determination by the Social Security Administration that the disabled party is no longer disabled.**

Covered Employee's Entitlement to Medicare before Qualifying Event

If the termination of employment or reduction in hours occurs less than 18 months after the date the covered employee becomes enrolled in Medicare, the covered employee's **spouse and dependent(s)** may be able to continue COBRA coverage for a period ending 36 months after the date of Medicare enrollment, if longer than the 18-month period after the termination of employment or reduction in hours. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his 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).

Subsequent Qualifying Events

If, *during the 18-month period of COBRA coverage (or within the 29-month maximum coverage period in the case of a disability extension)*, the covered employee and the spouse divorce, the covered employee dies, the employee becomes entitled to Medicare, or a dependent ceases to be a dependent under the terms of the Fund, then the **spouse and/or dependent(s)** (as applicable) may be able to extend COBRA coverage for up to **36 months** from the date of loss of coverage as a result of the termination of employment or reduction in hours, but only if the second event would have caused the spouse or child to lose coverage had the first qualifying event not occurred. **The covered employee, spouse or dependent or personal representative of the employee, spouse or dependent must provide written notice to the Fund Office of the subsequent event no later than 60 days after its occurrence. If such written notice is not given, the spouse and/or dependent will not be entitled to the additional COBRA coverage.**

The law provides that COBRA coverage may end earlier than explained above for any of the following reasons:

- The Fund no longer provides the group health coverage to any employees;
- the premium for COBRA coverage is not paid on time;
- after the date of the COBRA election, you become covered under another group health plan that does not contain any preexisting condition exclusion or limitation that applies to you; or after the date of the COBRA election, you become covered under a group health plan that does have a preexisting condition exclusion or limitation that applies to you if the exclusion or limitation should not apply as a result of application of the requirements of the Health Insurance Portability and Accountability Act of 1996;
- after the date of the COBRA election, you first become enrolled in Medicare; or
- you cancel COBRA coverage.

You do not have to show that you are insurable to choose COBRA coverage. However, COBRA coverage is offered subject to your eligibility for such coverage. The Plan Administrator reserves the right to terminate COBRA coverage retroactively if you are determined to be ineligible for COBRA coverage.

IF YOU HAVE QUESTIONS
Questions concerning the group health coverage or your COBRA continuation of coverage rights should be addressed to the Fund Office.

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

KEEP THE FUND OFFICE INFORMED OF ADDRESS CHANGE
In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of your family members. You should also keep a copy for your records of any notices that you send to the Fund Office.

3-12 Highmark Direct-Pay Private Health Insurance Policies

If you do not wish to continue Fund coverage through COBRA, you may be able to enroll in a Highmark direct-pay private health insurance policy. These policies may also be available to anyone who has elected COBRA coverage through the Fund and the term of the COBRA coverage has expired. If your health coverage through the Fund terminates for any reason, except as specified below, you may be eligible for Highmark direct-pay private health insurance. For inquiries into these policies call Highmark's conversion policy department at 1-800-544-6679.

The Highmark private health insurance policies are not available if either of the following applies:

- You are eligible for another group health benefits program through your place of employment; or

- If your employer's program is terminated and replaced by another health care benefits provider.

Section 4 THE W.P.E.E. INSURANCE TRUST FUND DEATH BENEFIT

4-1 Death Benefit

If you die while a participant covered for benefits under the Fund, the Fund will pay a death benefit to your designated beneficiary in the following amount as determined by your age at death:

under 45 the death benefit is:	$90,000.00
45 through 49 the death benefit is:	$58,000.00
50 through 54 the death benefit is:	$38,000.00
55 through 59 the death benefit is:	$22,000.00
60 through 64 the death benefit is:	$14,000.00
65 through 69 the death benefit is:	$10,000.00
70 and over the death benefit is:	$ 4,000.00

Benefit coverage for this purpose does not include the temporary health care coverage available to participants under the COBRA continuation coverage provisions, nor does it include any benefit coverage provided to spouses or dependents.

No death benefit is payable for any loss of life which occurs within two years from the effective date of death benefit coverage if caused directly or indirectly, wholly or partly, by intentional self-destruction or intentional self-inflicted injury, while sane or insane.

4-2 Beneficiary

You may designate anyone you wish as your primary or contingent beneficiaries. You may change your beneficiary designations at any time by completing and filing another beneficiary card with the Fund office. All beneficiary designations, and any changes to the beneficiary designations may be made only on a beneficiary card filed with the Fund Office, and are effective only if received before death. To acquire a beneficiary card, call 412-432-1156.

A primary beneficiary is the person (or persons or trust) to whom the death benefit proceeds will be paid. If you designate more than one primary beneficiary, they (or the survivor(s) of them) will receive equal shares of the death benefit proceeds unless you designate otherwise.

You may also designate one or more contingent beneficiaries on the beneficiary card filed with the Fund Office. If the primary beneficiary is not living at your death, the death benefit proceeds will be paid to your contingent beneficiary. If you designate more than one contingent beneficiary, they (or the survivor(s) of them) will receive equal shares of the death benefit proceeds unless you designate otherwise.

It is essential that you have a beneficiary card on file at all times with the Fund Office. If there is no primary or contingent beneficiary at your death, a beneficiary will be designated for you under the terms of the Fund in the

following order: (1) spouse; (2) children; (3) parents; or (4) your estate or any testamentary or other trust you created to receive death benefits.

4-3 Filing for Death Benefits

The death benefit proceeds will be paid in full in accordance with the above upon receipt of complete proof of death.

4-4 Facility of Payment

If a beneficiary entitled to payment of the death benefit proceeds is legally incapable of giving valid receipt for said payment, the Fund may pay the death benefit proceeds to the legal guardian or other legal representative of the beneficiary (in lieu of payment directly to the beneficiary). In the absence of a claim by the legal guardian or other legal representative, the Trustees may pay the death benefit proceeds to the following person or persons deemed by the Trustees to be charged with the care of such beneficiary: spouse, son, daughter, parent, brother, sister, or other person who has incurred expense for the personal care and maintenance of the beneficiary. Such payment, to the extent made, shall be a valid and complete discharge of any liability therefore under the Fund.

4-5 Decision on Benefit Payment

See the Claims and Appeals section (Section 17) for information on claims decisions and how to appeal a denied claim for death benefits.

Section 5 GENERAL PROVISIONS REGARDING THE FUND'S HEALTH PROGRAMS

5-1 Application for Fund Coverage

In order for your Fund coverage to take effect you must complete the application card and other enrollment materials supplied to you by the Fund. These materials must be promptly returned to the Fund Office.

5-2 Identification Cards

Once enrolled, the Fund Office and Giant Eagle Healthcare will issue you identification cards. Keep your cards with you at all times and use the appropriate card(s) whenever you receive health care services.

When to use which card:

- WPEE Insurance Trust Fund card for all medical and dental procedures (Sections 7, 8 and 11)
- Giant Eagle Healthcare card for obtaining maintenance prescription drugs at participating network pharmacies (reference Section 13).

5-3 Medical Necessity and Appropriateness

The health coverage programs under the Fund help pay for health care expenses that are determined by the programs' claims administrators to be medically necessary and appropriate. See below for what is considered medically necessary for all other Fund health programs.

To be medically necessary and appropriate, your tests, treatments, services and supplies must:

- Be appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury;
- Be provided for the diagnosis, or the direct care and treatment of your condition, illness, disease or injury;
- Be in accordance with standards of good medical practice;
- Not be provided primarily for the convenience of your provider or you; and
- Be the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered or your condition, and you cannot receive safe or adequate care as an outpatient.

The fact that your physician may prescribe, recommend, or provide treatment does not necessarily mean that the treatment is medically necessary and appropriate, as required by the Fund. The claims administrator for any particular program and the Fund reserves the right to determine, in their sole judgment, whether a service is medically necessary and appropriate.

5-4 Rights under the Women's Health and Cancer Rights Act

Under federal law, group health plans and health insurance issuers that provide medical and surgical benefits with respect to a mastectomy must provide certain benefits to a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction.

Specifically, the group health plan and issuer must provide coverage in a manner determined in consultation with the attending physician and the patient, for: (i) reconstruction of the breast on which the mastectomy has been performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and physical complications during all stages of mastectomy, including lymphedemas. This coverage may be subject to annual deductibles and coinsurance provisions, consistent with other benefits under the plan.

5-5 Rights under the Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours) as applicable. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or the newborn than any earlier portion of the stay. 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) as applicable.

5-6 Mental Health Parity

The health benefits under the Fund will comply with the Mental Health Parity and Addiction Equity Act of 2008 as required.

5-7 Genetic Information Nondiscrimination

The health benefits under the Fund will comply with the Genetic Nondiscrimination Act of 2008.

5-8 Provisions Under the Patient Protection and Affordable Care Act (PPACA).

The health benefits under the Fund will not discriminate in terms of benefit coverage based on any health status factors within the meaning of PPACA except as permitted by PPACA. Your coverage cannot be cancelled or discontinued with retroactive effect except in the case of fraud or intentional misrepresentation of a material fact and, even then, not before 30 days of advance written notice has been provided to each participant who would be affected by the rescission.

5-9 HIPAA Rules Regarding the Fund's Use of Protected Health Information

(a) Introduction. Regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) call for plan provisions detailing how Protected Health Information (PHI) may be shared with the Fund. This section functions as the HIPAA plan amendment referred to in the regulations at 45 C.F.R. § 164.504(f).

(b) Employment records. Employment records maintained by the Fund are *not* "health information" and therefore cannot be "protected health information." This includes, for example, records of date of hire, employment classification, and hours worked (even though that information may bear on eligibility for the plan), as well as medical information developed or received with respect to the Death Benefit.

(c) Disclosure to and use by the Fund Office and the Trustees. PHI may be disclosed to, and used by, the Fund Office or the Trustees for the purpose of carrying out plan administration functions, as long as the disclosure and use comply with the rest of this section. For example, this may include:

- determining eligibility for the plan or actual coverage under the plan,
- determining benefits under the plan, including coordination of benefits and subrogation,
- determination of premiums,
- billing, claims management, collection activities, collecting on stop-loss insurance, and related data processing,
- determinations of medical necessity, appropriateness, or justification of charges,
- utilization review, pre-certification, and concurrent and retrospective review,
- case management,
- credentialing doctors and hospitals, as well as training, accreditation, certification, and licensing,
- underwriting, premium rating and other activities relating to creating, renewing or replacing a health insurance contract or stop-loss contract (provided some additional rules are met),
- conducting or arranging for medical review, legal services, and auditing functions,
- business planning and development, such as conducting cost management and other analyses relating to managing and operating the Fund, including development of formularies, methods of payment and coverage policies, and
- management and general administration of the Fund, including customer service, resolution of grievances, and due diligence in connection with a sale or transfer of assets to another plan.

In addition, the Fund Office and the Trustees may avail themselves of any other exemption provided in the regulation.

PHI may not be disclosed to, or used by, the Fund Office or the Trustees for any purpose other than carrying out the plan administration functions that the Fund Office and the Trustees perform. Specifically, PHI may not be disclosed to, or used by, the Fund Office or the Trustees for the purpose of employment-related actions or decisions, or in connection with any other benefit or employee benefit plan.

(d) **Summary health information**. The Fund (or any insurance company) may also disclose PHI to the Fund Office and the Trustees if they request it for the purposes of (a) obtaining premium bids from health plans for providing health insurance coverage under the Fund or (b) modifying, amending, or terminating the Fund, as long as the information is in summary form. Summary form means that the information summarizes claims history, claims expenses, or types of claims under the plan and is "disidentified" in accordance with the regulation, except that it need only be aggregated to the level of five-digit zip codes.

(e) **Other protections for PHI**. Except as just described with respect to summary health information, the Fund Office and the Trustees agree:

- not to use or further disclose PHI except as permitted or required by the Fund (including this section) or as required by law;
- to ensure that any agents, including a subcontractor, to whom it provides PHI agree to the same restrictions and conditions that apply to the Fund Office and the Trustees, including implementation of reasonable and appropriate security measures;
- not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;
- to report to the Fund any use or disclosure of the PHI which it receives under this section that is inconsistent with these rules of which it becomes aware;
- to provide access to PHI about an individual to that individual in accordance with the regulations (45 C.F.R. § 164.524);
- to make PHI available for amendment and incorporate any amendments in accordance with the regulations (45 C.F.R. § 164.526);
- to make available the information required to provide an accounting of disclosures in accordance with the regulation (45 C.F.R. § 164.528);
- to make their internal practices, books, and records relating to the use and disclosure of PHI received from the Fund available to the Secretary of Health and Human Services for the purpose of determining compliance with the regulation by the Fund;
- to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that they create, receive, maintain, or transmit on behalf of the Fund;
- to ensure that the adequate separation required by the regulation (45 C.F.R. § 164.504(f)(2)(iii)) is established and supported by reasonable and appropriate security measures; and
- if feasible, to return or destroy all PHI received from the Fund that they still maintain in any form, and retain no copies, when no longer needed

for the purpose for which the disclosure was made and, if not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(f) **Disclosure to and use by others**. PHI may be disclosed to and used by entities other than the Fund Office or Trustees only pursuant to a "business associate" agreement assuring that the PHI will be used only for treatment, payment, or health care operations.

Section 6 HIGHMARK ADMINISTERED HOSPITALIZATION PROGRAM

The Fund has contracted with Highmark to administer your Hospitalization Benefits. The details of these benefits, including what is covered, what is excluded, and how to make a claim for benefits, are described in the booklet prepared by Highmark, which is incorporated into this document by reference.

For a copy of the most recent Highmark benefit booklet, please contact the Fund Office.

7-1 Payment of Benefits

Customary and Reasonable Method
Customary and Reasonable means that the fee determined and payable for covered services in accordance with:

> The **Customary Fee** is based on charges made by most providers of the same specialty in comparable geographical areas for the procedure performed.
>
> The **Reasonable Fee** (which may differ from the Customary Fee) is determined by considering unusual clinical circumstances; the degree of professional involvement; or the actual cost of equipment and facilities involved in providing the service.

Payment for services performed by providers will be made on the basis of the Customary and Reasonable allowance or the amount charged, whichever is less. Such payment will constitute full discharge of the Fund's liability under the medical/surgical portion of the program. Should you receive a balance bill from a provider, you may contact the Fund office to have it processed through the Major Medical portion of your benefits. The participant shall be responsible for payment of all or part of the balance bill applied to the deductible or any remaining charges.

7-2 Providers of Service

Providers of Service include, but are not limited to:

Audiologist
Clinical Laboratory
Doctor of Dental Surgery
Doctor of Medical Dentistry
Doctor of Osteopathy
Doctor of Podiatry
Medical Doctor
Nurse Midwife

Not all types of health care professionals are eligible providers under the Fund's Medical/Surgical Program. Please contact the Fund office at 1-800-382-1428 with any questions about the providers.

7-3 Covered Expenses

(a) Surgery (In or Out of Hospital)

Benefits are provided for surgical services required for treatment of disease or injury when performed by the provider in charge of the case. Covered are surgical services to correct birth defects and cosmetic surgery

performed to correct conditions resulting from an accident occurring on or after the effective date of this coverage.

The Customary and Reasonable allowance includes the post-operative care normally provided by the operating surgeon as part of the surgical procedure.

Benefits may also be provided for services of a provider who actively assists the operating surgeon when you are an inpatient. However, if the surgical assistance is performed by a provider who himself performs and bills for another surgical procedure during the same operative session, payment will not be made for the services of surgical assistants.

(b) Obstetrical Services (In or Out of Hospital)

Benefits are available to a female participant or to the enrolled wife of a male participant for obstetrical services, including prenatal and postnatal care, performed by a provider.

(c) Newborn Care (In-Hospital)

Benefits will be provided for routine care of a newborn infant by a provider during the mother's confinement in an accredited hospital.

(d) Anesthesia (In or Out of Hospital)

Benefits are provided for the administration of anesthesia in connection with covered services when rendered by or under the direct supervision of a provider, other than the surgeon or assistant surgeon. Anesthesia services consist of the administration of an anesthetic agent or anesthetic drug by injection or inhalation.

(e) Chemotherapy (In or Out of Hospital)

Benefits are provided for the administration of chemotherapy in connection with covered services when rendered by a provider.

(f) Radiation Therapy (In or Out of Hospital)

Benefits are provided for treatment by X-ray, gamma ray, accelerated particles, mesons, or neutrons when performed and billed by a provider. The cost of the radioactive material supplied and billed by the provider is covered.

(g) Diagnostic Services (In or Out of Hospital)

Benefits are provided for diagnostic services required in the diagnosis of a condition due to illness, disease or injury consisting of:

- Diagnostic radiology services performed and billed for by a provider;
- Diagnostic medical services such as cardio graphic and encephalographic testing, radio-isotopic studies and other procedures which may be approved by the Fund when performed and billed for by a provider;

- Pathology tests (laboratory tests) when performed, billed for, or ordered by a provider;

- Diagnostic and pathological testing charges incurred in connection with the routine physical examination of each eligible family member; and

- Diagnostic testing needed to diagnose an infertility condition.

(h) Allergy Testing (In or Out of Hospital)

Benefits are provided for allergy testing (to diagnose) when performed, ordered, or billed by a provider. The allergy extract (the injection of the serum and the serum itself) and the office visit in connection with the allergy testing is processed through the Major Medical benefits.

(i) Emergency Medical Care

Benefits are provided for the outpatient treatment of emergency medical care. Emergency medical care is the initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity or severe pain that the absence of immediate medical attention could reasonably result in:

- Permanently placing the patient's health in jeopardy;

- Causing serious and permanent dysfunction of any bodily organ or part;

- Causing serious impairment to bodily functions; or

- Causing other serious medical consequences.

Benefits are provided for emergency dental treatment required due to any accidental injury which occurred on or after the effective date of coverage.

Treatment must commence within 48 hours after the onset of the medical emergency.

(j) Transplant Services

Benefits are provided for transplant services performed by a provider for a participant, including the services for the removal of an organ from a donor when the donor is not a participant and not covered under another health care plan.

(k) In-Hospital Medical

Benefits are provided for medical services by the provider in charge of the case for treatment of conditions other than surgery, obstetrical delivery, or radiation treatment. These services are available for a total of 365 days for each period of hospitalization. At least 90 consecutive days must elapse between discharge from and subsequent admission to a hospital or a skilled facility before inpatient stays will be considered a new period of hospitalization.

Days of treatment by the provider in charge of the case for mental health care, inpatient detoxification (substance abuse) and inpatient rehabilitation

for alcoholism or drug abuse will be applied against any inpatient medical stays as previously described.

(l) Concurrent Care (In-Hospital)
Benefits are provided for inpatient medical services by a provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the patient, stand-by services, routine pre-operative physical examinations or medical care routinely performed in the pre- or post-operative or pre- or postnatal periods.

(m) Consultation (In-Hospital)
Benefits are provided for consultations if required by the patient's medical condition and the provider in charge of the case requests the consultation. You are limited to one consultation per consultant during any one inpatient stay.

(n) Mammography Screening
Benefits will be provided for one routine mammogram screening per calendar year for participants and dependents. Benefits are not subject to any maximum.

(o) Routine Gynecological Exam and Pap Smear
Benefits will be provided for all females, regardless of age, for one routine gynecological examination and one routine Pap smear per calendar year. Benefits are not subject to any maximum. The claim must clearly state "**Gynecological exam**".

(p) Childhood Immunizations
Benefits are provided for those childhood immunizations, including immunizing agents, which conform to the standards of the U.S. Department of Health and Human Services. Benefits are limited to dependent children and are not subject to any maximum.

(q) Adult Immunizations
Benefits are provided for shingle and pneumonia, and flu immunizations.

(r) Well-Care Child Visits
Benefits will be provided for well child visits for dependent children up to the age of seven (7). Benefits are not subject to any maximum.

(s) Routine Physical Exam
Benefits are provided for routine physical examinations (up to $150 maximum per visit prior to January 1, 2020 and up to $500 maximum per visit on and after January 1, 2020) for each family member. The claim must clearly state "**Physical Exam**".

(t) Impacted Teeth (In or Out of Hospital)
Benefits are provided for services performed by a provider for the extraction of impacted wisdom teeth which are partially or totally covered by bone.

(u) Unusual Travel
Benefits will be paid up to a maximum of $800.00. This benefit is provided for local transportation by a vehicle designed, equipped and used only to transport the sick and injured:

- From your home, scene of accident or medical emergency to a hospital;
- Between hospitals;
- Between hospital and skilled nursing facility; or
- From a hospital or skilled nursing facility to your home.

Trips must be the closest local facility that can give covered services appropriate for the patient's condition. If none, you are covered for trips to the closest facility outside your local area.

Should there be an unpaid portion of the initial charge amount, it will automatically be processed under the Major Medical benefits.

(v) Hearing Aids

When prescribed by a medical doctor, benefits will be paid for no more than two (2) hearing aids every four (4) calendar years with a limit of one (1) hearing aid per ear with a maximum allowance of $2,100 per hearing aid. **Hearing aids are not payable through the Major Medical portion of the benefits.**

(w) Diabetic Education

When the attending physician certifies that the patient requires diabetes education as an outpatient, benefits will be provided for the following services when rendered by an approved outpatient diabetes education program:

- Up to a maximum of four outpatient visits during a calendar year for initial assessment and education. The initial four visits will be provided only once during the patient's lifetime.
- After completion of the initial visits and review of areas in which competency was not achieved, benefits for post-assessment of the patient's competency will be limited to two outpatient visits within the calendar year in which the initial visits were completed.
- Subsequent outpatient visits for follow-up education and to refresh existing knowledge as well as present techniques which are appropriate for management of the diabetes condition will be limited to two per calendar year.

(x) Cardiac Rehabilitation

Services performed by a provider for cardiac rehabilitation, which are regulated exercise programs that are effective in the physiological and psychological rehabilitation of many patients with cardiac conditions, are provided up to a maximum of 36 sessions. Payment may be made for certain services performed in conjunction with these programs if the patient is referred by the attending physician and has had:

- a previous coronary bypass surgery;
- a diagnosis of stable angina pectoris; or
- a myocardial infarction within the preceding 12 months.

7-4 Expenses Not Covered

The following shall not be considered covered Medical/Surgical expenses:

- Services performed by a registered professional nurse employed by a health care facility or by an anesthesiology group;

- Services for any condition due to illness or injury covered by Workers' Compensation Laws or similar legislation;

- Services provided or paid for by any government or its agencies;

- Services provided under any governmental program for which any periodic payment of rate is made by or for the subscriber;

- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;

- Services for which the subscriber recovers the cost by legal action or settlement;

- Pre-operative care when the subscriber is not an inpatient and post-operative care other than that normally provided following operative or cutting procedures;

- Services in connection with research or experimental studies that are not generally accepted medical practices in the U.S. for a given illness;

- Pre-marital or pre-employment examinations, and any services the Fund deems not related to the diagnosis or treatment of a sickness or injury;

- Services directly related to the care, filling, removal or replacement of teeth, or diseases of the teeth, gums or structures directly supporting or attached to the teeth (these include, but are not limited to, apicoectomy [root resection], root canal treatment, soft tissue impaction, alveolectomy, and treatment of periodontal disease except if incurred due to an accidental injury;

- Treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimension and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;

- Correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy, and all related services;

- Operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected. However, benefits are payable to correct a condition resulting

from an accident which occurs while the patient is covered by the Fund. The patient must be enrolled without interruption from the date of the accident to the date of the operation to be eligible for the corrective surgery. Benefits are also payable to correct functional impairment which results from any covered disease, injury or congenital birth defect;

- Treatment of bunions (except by capsular or bone surgery), toe nails (except surgery for ingrown nails), corns, calluses, fallen arches, flat feet, weak feet, chronic foot strain or symptomatic complaints of the feet;

- Services performed by provider enrolled in an education or training program when such services are related to the education or training program;

- Charges for completion of any insurance forms or services for which the subscriber incurs no charge;

- Services performed for a subscriber by a spouse, parent or child of that subscriber;

- Clinical pathology services for which a hospital or institution bills for the technical component of the service and the provider bills for the professional component of the service;

- Services performed prior to your effective date of coverage or during an inpatient admission that commenced prior to your effective date;

- Any other medical or dental service or treatment except as provided in this document;

- Services rendered on behalf of a dependent daughter for pregnancy care (child birth, miscarriage, c-section, pre/post-natal care);

- For any treatment in connection with transsexual surgery, except for sickness or injury resulting from such surgery;

- For sexual dysfunction not related to organic disease;

- For services performed and/or the treatment of infertility including but not limited to drug therapy, UI (Intrauterine Insemination), ART (Assisted Reproductive Technologies), and all related services;

- Nutritional counseling and services intended to produce weight loss including dietary or food supplements;

- Routine physical examinations and immunizations, except as provided herein;

- Over-the-counter supplies;

- Genetic testing;

- All services solely related to a family history diagnosis without a medical diagnosis of a sign or symptom;

- Elective abortions. Non-elective induced abortions will be covered. Non-elective induced abortions are those:
  - Necessary to avert the death of the mother;
  - Performed in a case of pregnancy which is the result of rape; and
  - Performed in a case of pregnancy which is the result of incest.

- Services other than described in this Section deemed not to be medically necessary or medically appropriate by the Fund.

7-5 Claims and Appeals

The procedures for filing Medical/Surgical claims are explained in Sections 9 and 10. The claim processing and appeal procedures are explained in Section 17.

8-1 Catastrophic Major Medical Expense Program

The Catastrophic Major Medical Expense Program is designed to supplement the Hospitalization Program benefits described in Section 6 and Medical/Surgical Program benefits described in Section 7 by providing additional protection against the expenses incurred due to non-occupational injury or sickness. The Major Medical Expense Program will reimburse you to a large extent for medical expenses not covered in full or not covered at all by the Hospitalization program and Medical/Surgical Program.

8-2 Covered Major Medical Expenses

The term "Covered Major Medical Expenses" refers to the necessary, reasonable, and customary charges for the services listed below when rendered for the treatment of a non-occupational injury or sickness and which are performed or prescribed by a licensed professional provider.

Providers of Service include but are not limited to:

Ambulance Service Professional
Audiologist
Clinical Laboratory
Doctor of Chiropractic
Doctor of Osteopathy
Doctor of Podiatry
Licensed Acupuncturist
Licensed Pharmacist
Medical Doctor
Mental Health Practitioner
Nurse Midwife
Occupational Therapist
Physician's Assistant
Physical Therapist
Speech Therapist

SPECIAL NOTE: Treatment performed by a physical therapist, occupational therapist, or a speech therapist must be prescribed by a licensed physician.

Not all types of health care professionals are eligible providers under the Fund. Please contact the Fund Office with any questions about the providers.

Covered Expenses include:

- Services of a professional provider (in or out of hospital) including those charges in excess of the Medical/Surgical Program benefit allowances. This includes visits in the outpatient department of a hospital, doctor's office, or home (coverage for home visits available to the employee only, not available to dependents) for illness or injury;

- Oxygen and rental equipment for the administration thereof;

- Blood and blood plasma, in excess of two pints during each calendar year, to the extent that it is not donated or replaced;

- Rental of durable medical or surgical equipment under a lease acceptable to the Fund. The Fund may, at its discretion, authorize purchase of such equipment by you;

- Artificial limbs and artificial eyes;

- Orthopedic braces (except corrective shoes) and prosthetic appliances. Replacement of such devices is not covered except in the case of dependent children when the professional provider in charge of the case certifies that such replacement is necessary;

- Professional ambulance service when used in emergency situations to transport the patient from the place where he is injured or stricken by disease to the nearest hospital where required treatment is given, and local professional ambulance service when used in non-emergency situations to transport the patient to or from a hospital for required treatment, provided the attending professional provider certifies that such transportation is medically necessary. No other charges for transportation will be covered;

- Skilled nursing facility services once Highmark Blue Cross allowances have been exhausted;

- Smoking deterrents prescribed by a doctor, up to $500.00 a lifetime;

- Allergy extract (the injection of serum and the serum itself) and the office visit in connection with allergy testing;

- Inhalation/respiratory therapy;

- Speech and occupational therapy;

- Physical therapy (after Highmark Blue Cross coverage);

- Emergency Room charge for the treatment of conditions which are diagnosed not to be life-threatening, will not permanently place the patient's health in jeopardy, will not cause serious and permanent dysfunction of any bodily organ

or part, will not cause serious impairment to bodily functions or will not cause other medical consequences;

- Prosthetic devices including parts and labor; and orthotics, only when custom molded with a limit of one pair per calendar year per family member;

- Tetanus shots, if provided as part of a routine physical examination; and

- Chiropractic/Acupuncture visits - limited to 26 visits per calendar year per person for either chiropractic services, acupuncture services, or a combination of the two. Services are subject to the coinsurance, deductibles and maximum reimbursements specified in Section 9-4. Durable medical equipment and medical supplies prescribed by a chiropractor or acupuncturist are not covered.

Please note that you do not have to receive hospital care under the Hospitalization Program before the Major Medical Expense Program takes effect. Also, the Major Medical Program may be used without the use of the Hospitalization Program or Medical/Surgical Program (for services not covered by the Hospitalization Program or Medical/Surgical Program); along with the use of the Hospitalization Program or Medical/Surgical Program (supplementing the Hospitalization Program or Medical/Surgical Program); or before and after the use of the Hospitalization Program or Medical/Surgical Program (for services not covered by the Hospitalization Program or Medical/Surgical Program).

(a) Outpatient Mental Health Care

The Major Medical Program will pay for therapy services performed by a mental health practitioner subject to the deductibles, coinsurance and maximum reimbursements specified in section 9-4.

A mental health practitioner includes, but is not limited to, a physician, licensed mental health counselor, licensed professional counselor, psychologist, or licensed social worker who is legally licensed to treat mental and nervous disorders.

(b) Prescription Drugs

Other than the special co-pay amount for maintenance prescription drugs that you have filled through the Prescription Drug Program described in Section 14, you may submit a claim under the Major Medical Expense Program for amounts you pay for prescription drugs.

Reimbursements for prescription drugs are subject to the coinsurance, deductibles and maximum reimbursements specified in Section 8-4.

8-3 Expenses Not Covered

The following shall not be considered covered Major Medical expenses:

- Services performed by a registered professional nurse, registered nurse practitioner, licensed practical nurse employed by a health care facility or by an anesthesiology group;

- Charges for hospital room, board, and general nursing care which have been disallowed by Blue Cross;

- Care in a nursing home, home for the aged, or convalescent home;

- Services provided or paid for by any government or its agencies;

- Services covered in whole or in part by any workers' compensation laws, or any services which the employer is required by law to furnish;

- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or services are paid or payable under any applicable motor vehicle insurance policy or program, including a certified or qualified plan of self-insurance, or any catastrophic loss fund established by law;

- Services not prescribed by the attending professional provider as being necessary for the treatment of an illness or injury;

- Charges in excess of the fair and reasonable value of the service rendered;

- Charges for any dental work or treatment except for balance due bills from Medical/Surgical procedures;

- Charges for treatment of corns, bunions (except capsular or bone surgery), calluses, nails of the feet, except surgery for ingrown nails, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except when surgery is performed;

- Services received as a result of injury or sickness due to an act of war, declared or undeclared;

- Personal expenses such as barber services, guest meals, rental of radio, TV, or air conditioners, etc.;

- Eyeglasses or contact lenses (except for one pair of eyeglasses or contact lenses and examinations for their prescription or fitting following a cataract operation);

- Operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected. However, benefits are payable to correct a condition resulting from an accident which occurs while the patient is covered by the Fund. The patient must be enrolled without interruption from the date of the accident to the date of the operation to be eligible for cosmetic surgery. Benefits are also payable to correct functional impairment which results from any covered disease, injury or congenital birth defect;

- Services rendered on behalf of a dependent daughter for pregnancy care, (childbirth, miscarriage, or cesarean section, or prenatal or postnatal);

- Services for which the subscriber recovers the cost by legal action or settlement;

- Treatment of temporomandibular joint syndrome (jaw hinge) with intra-oral prosthetic devices, or any other method to alter vertical dimension and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;

- Charges for the completion of any insurance forms or services for which the subscriber incurs no charge;

- Services performed for a subscriber by a spouse, parent, or child of that subscriber;

- Marriage and family counseling;

- Orthoptic therapy;

- Nutritional counseling and services intended to produce weight loss;
- Services for the treatment of infertility including but not limited to drug therapy, UI (Intrauterine Insemination), ART (Assisted Reproductive Technologies), and all related services;

- Durable medical equipment or medical supplies prescribed by a chiropractor or acupuncturist;

- Over-the-counter supplies, except smoking deterrents only if accompanied by a letter of medical appropriateness or a prescription from a medical physician;

- Anti-abuse drugs;

- Services and supplies not provided in accordance with professional standards acceptable to the Fund; and

- Expenses for gene therapies, including, but not limited to, Chimeric Antigen Receptor T-Cell (CAR-T) Therapies (e.g., Kymriah and Yescarta) and ocular gene therapy (e.g., Luxturna).

8-4 Extent of Payment

(a) Deductible

The annual deductible is $250.00, which you are required to pay for covered major medical expenses incurred during each calendar year.

There is a separate annual deductible of $250.00 for each covered dependent. However, if within the same calendar year three or more persons in your family incur covered major medical expenses, the deductible will be limited to an aggregate of $500.00 per family during a calendar year.

Covered Major Medical Expenses incurred during the last three months of any calendar year which are used to satisfy all or part of the Deductible for

that year will be credited toward the Deductible required in the following calendar year.

(b) Coinsurance

For an individual, if you incur covered major medical expenses in excess of the $250.00 annual deductible, the Major Medical Program will pay 80% of the first $2,000 of such expenses in a calendar year and 100% of expenses in excess of $2,250 in a calendar year. (Ex: $250 individual deductible "+" $400 the individual patient's responsibility = $650 patient's total out-of-pocket)

For a family, if you incur covered major medical expenses in excess of the annual $500.00 family deductible, the program will pay 80% of the first $2,000 of such family expenses in a calendar year and 100% of family expenses in excess of $2,500 in a calendar year. (Ex: $500.00 family deductible "+" $400 coinsurance = $900 family total out-of-pocket)

8-5 Understanding the terms "Covered" vs. "Paid" Procedures

When calling the Fund Office to inquire if a major medical procedure is "COVERED", the caller must understand that when they are told the procedure is "COVERED", this does not necessarily mean that "IT WILL BE "PAID" under the Major Medical Benefit, the deductible must be considered.

8-6 Claims and Appeals

The procedures for filing major medical claims are explained in Section 9. The claim processing and appeal procedures are explained in Section 17.

Section 9 HOW TO FILE A MEDICAL/SURGICAL AND MAJOR MEDICAL CLAIM

9-1 Filing of Medical Claims

Request a medical claim form from the Fund Office.

- A form must accompany all claims;
- Use one claim form for each family member;
- You must complete Box #1 through #12 at the top portion of the medical form. Box #13 must be signed or indicate "Signature on File" if the payment is to be submitted directly to the provider (also known as "Assignment of Benefits");
- The doctor or provider should complete Box #15 through #34 of the medical form, or attach a self-explanatory itemized bill including CPT procedure code(s) and an ICD-10 diagnosis code to the claim form;
- Be sure all your answers to all questions on the claim form are complete and correct;
- Include the original bill. Photocopies or faxed bills, unless approved by the claims administrator, will result in denial of the claim;
- **Statement of Account and Balance Forward Bills are acceptable for balance bills <u>only</u>**; these must be originals. If payment is to be issued directly to the provider of service, Box #13 on a medical claim form must be signed or indicate "Signature on File". Submit the claim form with the balance bill;
- Canceled checks, cash register tapes, Highmark Blue Cross Blue Shield Explanation of Benefits, and denials are not claims and cannot be accepted;
- Claims should be submitted at least every 2 months, however they MUST be received by the Fund Office no later than 12 months from the end of the calendar year for which the benefits are payable;

Example

Date of service 01-01-2019 must be received by 12-31-2020
Date of service 12-31-2019 must be received by 12-31-2020

- **If the claim is the result of an accident**, you will be required to fill out an Accident Claim Information Form and a Reimbursement/Subrogation Acknowledgment Agreement;
- **For durable medical equipment and prosthetic devices**, a letter of medical necessity from the attending physician must accompany the claim.

Included must be the rental fee purchase price for the equipment and the length of time the equipment will be required; and

- **When "Coordination of Benefits" is applicable** (see Section 15), you must submit the Explanation of Benefits form from any other insurance carrier along with an itemized bill. **Balance due bills are not acceptable.**

9-2 Filing of Private-Duty Nursing Claims

Claims for Private-Duty Nursing Care must contain:

- The shift(s) worked;
- Charges per day;
- Professional status of the nurse; and
- Signature of physician prescribing the service.

9-3 Filing of Prescription Drugs and Medical Claims

Prescription Drug and Medical claims must show:

- Prescription number;
- Date of purchase;
- Patient's name;
- Physician's name; and
- The original bill (photocopies will result in denial of the claim).

Your attending physician must certify that he prescribed all services by signing his name on all bills, except doctor bills, hospital bills, or prescription bills. Bills requiring signature of physician and a letter of medical necessity include but are not limited to: ambulance bills, prosthetic devices, rental of durable equipment, private-duty nursing, etc. Itemized bills will not be returned.

FAILURE TO FOLLOW ANY OF THESE PROCEDURES MAY RESULT IN A DELAY OF PAYMENT OR DENIAL OF THE CLAIM.

IT IS NOT ALWAYS NECESSARY THAT YOUR DOCTOR COMPLETE A PROVIDER'S HEALTH CLAIM FORM OR A FUND HEALTH CLAIM FORM. If you have an itemized bill from your doctor which is self-explanatory and contains the required information, you may attach that bill to the claim form instead of having the doctor fill out the information. **However, your portions of the claim for PATIENT and INSURED INFORMATION must <u>always</u> be completed.**

The Fund will process the claim within 30 days of receipt unless special circumstances require an extension of time. See Section 17 for claim processing.

The completed claim form, with all itemized bills or itemized receipts attached, should be sent to the Fund Office.

You can contact the Fund Office with any questions or problems concerning your claims.

9-4 Procedures for Processing Claims and Filing Appeals

The procedures for processing claims and for filing and processing appeals of denied claims are contained in Section 17.

Section 10 AETNA-MERITAIN HEALTH PPO PROGRAM

10-1 Aetna-Meritain Health PPO

The Fund provides participants with the option of seeking medical/surgical and major medical care through providers that have contracted with the Aetna-Meritain Health PPO. A PPO (Preferred Provider Organization) is a network of doctors, diagnostic facilities and other health care providers who discount their charges in exchange for prompt payment of claims and more patient volume. **The Aetna-Meritain Health PPO is not an HMO** (Health Maintenance Organization).

There are no referrals nor is it necessary to select a primary care physician. The Aetna-Meritain Health PPO option was added to the Fund in an effort to reduce contribution dollars needed while, at the same time, decreasing your out-of-pocket expenses. If you seek care from a provider who is participating in the Aetna-Meritain Health PPO on the date of service, the provider's charges will be discounted in accordance with the PPO allowance.

If you do not use an Aetna-Meritain Health provider, you may be balanced billed. Providers that have contracted with the Aetna-Meritain Health PPO have agreed not to balance bill participants of the Fund above the PPO's allowable charges. If you feel that you were inappropriately balance billed by a provider that is participating in the Aetna-Meritain Health PPO, or to simply inquire if a provider is a participating provider, please contact the Fund Office.

Under the Major Medical Program, you still need to meet the $250 individual/$500 family deductible and $400 out-of-pocket. However, if you choose to use an Aetna-Meritain Health participating provider, there will be a reduced rate for procedures.

Example

- Dr. Smith normally charges $75 for an office visit.
- As an Aetna-Meritain Health participating provider, he could charge you only $60 resulting in a $15 savings for you.

The following are answers to the most commonly asked questions the Fund has been receiving pertaining to the Aetna-Meritain Health PPO Program benefit:

- This is not an HMO. PPO simply means, "Preferred Provider Organization".
- Procedures which are covered through the Dental Program and Optical Program portions of your benefits are not eligible under the Aetna-Meritain Health PPO.
- To order additional WPEE ID cards call the Fund Office.

10-2 Claim Filing

You do not need to file a claim when you receive services from an Aetna-Meritain Health provider. Claims are submitted by the provider.

10-3 Claims Processing and Appeal Procedure

The procedures for processing claims and for filing and processing appeals of denied claims are contained in Section 17.

10-4 Aetna-Meritain Health Provider Network

The Aetna-Meritain Health provider network is always growing and new providers are regularly added to the program. It is also possible that a provider listed in the directory may not have renewed their contract with the Aetna-Meritain Health PPO. As such, you should call toll-free 1-800-476-9971 before obtaining medical services. In addition, if a provider is not listed in your directory, you should call to determine whether that provider is a participant in the network. You may also check the Aetna-Meritain Health PPO web site at https://**Error! Hyperlink reference not valid.**www.aetna.com/docfind/custom/mymeritain/.

Section 11 W.P.E.E. INSURANCE TRUST FUND DENTAL PROGRAM

This program is designed to provide benefits towards expenses incurred by eligible participants and their dependents for dental services all in accordance with the definitions and limitations hereinafter set forth.

11-1 Limitations and Benefits

- During a calendar year, January 1 through December 31, the maximum allowance for each family unit will be $2,000.00.

- The Program pays 80% of all dental charges up to a maximum allowance of $2,000.00 for each family unit, as set forth above; (80% of $2,500.00 of charge amounts = $2,000.00 allowance).

    - As an exception, pediatric dental services which are considered "essential health benefits" under healthcare reform, will not be subject to the $2,000 annual maximum. Therefore, any such pediatric dental services will be paid at 80% even after the $2,000 family maximum has been met; however, the cost of the pediatric services will still be included in calculating whether the $2,000 annual maximum has been met by the family unit.

- Prescription drugs for dental care are processed under Major Medical benefits;

- For orthodontic treatment, payment will be allowed for the initial down payment with a maximum allowance of $1,000. Thereafter, the claims must be submitted based on a scheduled payment plan. Cosmetic orthodontia is not considered an essential health benefit and is therefore subject to the $2,000 maximum; and

- If you have reached the maximum allowance in a calendar year, any charges above the maximum allowance incurred in the last three (3) months of that year may be applied to the following calendar year. **The charges are to be submitted to the Fund Office in the year following the date of the charges.**

Example

If the maximum allowance was reached in September, a dental claim for services rendered in October, November, or December cannot be submitted until after January 1st.

11-2 Filing a Dental Claim

The itemized bill showing the original date of service must be received by the Fund Office no later than 12 months from the end of the calendar year for which the benefits are payable. Only original bills will be accepted. Submission of photocopies will result in denial of the claim.

Example

Original date of service 01-01-2019 must be submitted by 12-31-2020
Original date of service 12-31-2019 must be submitted by 12-31-2020

- Payment for dental services and supplies can be made directly to the provider by the Fund. The dental provider should submit claims for payment to the Fund Office.

- The limitations as to the maximum allowance per calendar year for services rendered or supplies furnished shall be based on the time when the bills for these services are received in the Fund Office. Only claims incurred during the period when the participant was qualified for benefits will be considered for payment.

Required Information for the Processing of Dental Claims

- The original date of service (month/day/year) must be included on the bill;

- The original bills; photocopies and faxed bills, unless approved, will result in denial of the claim;

- The participant's name;

- The participant's DH number;

- The name and address of the place of service;

- The name of the patient;

- An itemized description of the services;

- If payment is to be made directly to the provider of services, the claim form or bill must include your signature of authorization; and

- When "Coordination of Benefits" is applicable (see Section 15), you must submit the Explanation of Benefits form from any other insurance carrier along with an itemized bill. Balance due bills are not acceptable.

FAILURE TO INCLUDE ANY OF THIS INFORMATION MAY RESULT IN DELAY OF PAYMENT OR DENIAL OF THE CLAIM.

11-3 Procedures for Processing Claims and Filing Appeals
The procedures for processing claims and for filing and processing appeals of denied claims are contained in Section 17.

Section 12 W.P.E.E. INSURANCE TRUST FUND OPTICAL PROGRAM

This program is designed to provide reimbursement towards the expenses paid and incurred by eligible participants for optical services and supplies all in accordance with the definitions and limitations hereinafter set forth.

12-1 Limitations and Benefits

(a) Limitations

- For adults, during any calendar year (January 1 through December 31), payment will be made for no more than one routine eye examination per family member;

- For children under age 19, there is no limit on the number of eye examinations per child during a calendar year; however, the exam is subject to the allowance listed in section 12-1(b);

- For adults, benefits will be paid for no more than two lenses (i.e. 1 left lens, 1 right lens) per family member during any calendar year;

- For children under age 19, benefits will be paid for no more than two lenses (i.e. 1 left lens, 1 right lens) per child per visit with an eye examination; benefits will be paid for lenses or contact lenses, but not both in one visit;

- For adults, benefits will be paid for no more than one frame *per family member* during any period of two calendar years;

- For children under age 19, benefits will be paid for no more than one frame per child per visit with an eye examination;

- The Program will pay for one pair of safety glasses in addition to a pair of prescription glasses for participants working at the trade; and

- Non-prescription glasses (excluding safety glasses) are not covered under this Program.

If during a calendar year you received reimbursement for an eye exam, a set of lenses, and/or lens tinting/scratch coating and you receive or purchase any of these again in the last three (3) months of that year, you may apply these charges to the following year. The receipt is to be submitted to the Fund Office in the year following the year of the date of service or purchase.

Example

If you were reimbursed for single vision lenses in March, and you purchase contact lenses in October, you cannot submit the receipt for the contact lenses until after January 1st of the following year.*****

If in the prior calendar year you have received reimbursement for a frame and you purchase one in the last three (3) months of the current calendar year, the charges for this frame may be applied to the following year. The receipt is to be submitted to the Fund Office in the year following the year of the purchase.

Example

If you were reimbursed for a frame in the past December, and you purchase another frame in October of the current year, you cannot submit the receipt until after January 1st of the following year.*****

*** Reminder - This is per adult family member.**

(b) Benefits

The Program will allow toward the cost of all services and supplies specified below, the amount appearing next to each item respectively.

Service	**Allowance**
Eye Examination	$50.00

Lenses	**Allowance Per Pair**
Single Vision	$75.00
Bifocal	$110.00
Double Segment Bifocal (double segment bifocals for active participant only)	$175.00
Trifocal	$140.00
Progressive Bifocal or Trifocal	$140.00
Aphakic (replaces natural lens)	$200.00
Contact	$90.00
Frames	$75.00
Lens Tinting/Scratch Coating	$15.00

Safety Glasses

Reimbursement allowances follow the same schedule as above, and the same limitations as prescription glasses apply. In addition, safety glasses are not required to be prescription, but they must meet OSHA requirements and ANSI Z87.1 standards.

12-2 Filing an Optical Claim

- Each participant shall pay for optical services or supplies directly to the provider.

- The receipt for optical services must be received by to the Fund Office no later than 12 months from the end of the calendar year for which the benefits are payable. Only original receipts will be accepted. Submission of photocopies will result in denial of the claim.

Example

Date of service 01-01-2019 must be received by 12-31-2020
Date of service 12-31-2019 must be received by 12-31-2020

- The limitations as to the maximum amount to be reimbursed per calendar year for services rendered or supplies furnished shall be based on the time when the receipted bills for these services are received in the Fund Office. Only claims incurred during the period when the participant was qualified for benefits will be considered for reimbursement.

12-3 Required Information for the Processing of Optical Claims

- The original receipts (photocopies and faxed receipts, unless approved, will result in denial of the claim);

- The participant's name;

- The participant's DH number;

- The name and address of the place of service;

- The name of the patient;

- That payment was made and received **(to be marked by the provider of service not by the participant)**;

- The date of payment (month/day/year);

- A **BREAKDOWN** of the services;
  a. Charge for the eye examination
  b. Charge for the lenses

- Type of lenses (single vision, bifocal, contact, etc.)
  a. Charge for the lens tinting/scratch coating (if received)
  b. Charge for the frame

- **Special Note:** For safety glasses, the receipt must indicate that they are safety glasses. Be certain that the lenses and frame meet OSHA requirements and ANSI Z87.1 standards; and

- **When "Coordination of Benefits" is applicable** (see Section 15), you must submit the Explanation of Benefits form from any other insurance carrier along with an itemized bill. Balance due bills are not acceptable.

FAILURE TO INCLUDE ANY OF THIS INFORMATION MAY RESULT IN DELAY OF PAYMENT OR DENIAL OF THE CLAIM.

12-4 Procedures for Processing Claims and for Filing Appeals

The procedures for processing claims and for filing and processing appeals of denied claims are contained in Section 17.

Section 13 GIANT EAGLE HEALTHCARE RETAIL AND MAIL-SERVICE PRESCRIPTION DRUG PROGRAM

13-1 Prescription Drugs at Retail Pharmacies

- **Retail Pharmacy Benefit for Maintenance Medications**
  Maintenance medications are medications that are prescribed for more than 30 days.

  You should contact Express Scripts Member Services with questions as to whether a particular medication is covered.

  When you have your maintenance medications filled at a participating network pharmacy you are only responsible for the co-pay. Currently, co-pays for maintenance medications dispensed at a participating network pharmacy in quantities from 30-90 days' supply are $30 for brand name medication, $15.00 for formulary brand medications and there is no co-pay for generic drugs. **These co-pays may change**.

  If maintenance medications are filled at a pharmacy that is not a participating pharmacy you will be responsible for the entire cost of the medications. However, you may submit a claim for reimbursement under the Major Medical Expense Program described in Section 8. See Section 8 for information on reimbursement for prescription drug costs under the Major Medical Expense program and Section 9 for information on how to file a claim for reimbursement for prescription drugs under the Major Medical Expense Program.

- **Prescription Drug ID Card**
  Participants must present their prescription drug ID card at a participating network pharmacy in order to receive medications at the co-pay rates.

- **Participating Network Pharmacies**
  For a list of participating network pharmacies please visit www.express-scripts.com or call Express Scripts Member Services.

13-2 Prescription Drugs at Mail-Service Pharmacy

- Maintenance prescription medications may also be obtained through a mail-service pharmacy offered through Express Scripts.

- Currently, co-pays for maintenance prescription drugs filled through the Express Scripts mail-service pharmacy in quantities from 30-90 days' supply are $30.00 for non-formulary brand medications, $15.00 for formulary brand medications and there is no co-pay for generic drugs. **These co-pays may change**.

- Most maintenance prescription drugs are covered through this program. However, there are some exceptions because of state laws. To determine

whether your medications may be filled through the mail-service call Express Scripts Member Services.

Due to the shipping time required for mail-service orders, this program is not appropriate for one-time prescriptions, emergencies, or temporary conditions.

- If your doctor wants your prescription to be filled with a brand-name drug, he or she must indicate so on your prescription. Otherwise, your prescription will be filled with a generic drug, where available.

13-3 Ordering Drugs

- If your doctor prescribes a maintenance medication, you may ask for a 90-day supply with up to three refills. You may order less, but the cost will be the same for a 30-day supply as for a 90-day supply.

- If your doctor prescribes a new maintenance medication you may ask for two prescriptions - an initial prescription to monitor the medication's effect and a second prescription for a 90-day supply with refills.

13-4 Ordering Drugs through the Mail-Service Option

- For your first order only, complete the order form and patient profile. These materials are supplied to you in your Express Scripts welcome packet. Additional order forms may be obtained by calling Express Scripts Member Services.

- Check the prescription to make sure that it includes the correct dosage, the doctor's signature and the patient's name and address. Write your DH number on the back of the prescription.

- Mail the original prescription, the order form, the patient profile and the appropriate co-pay amount to the address specified on the Express Scripts order form. You must mail an order for each prescription. After that, you may order refills by calling Express Scripts Member Services.

- The prescription will be sent directly to your home. If you do not receive your prescription within 14 days, call Express Scripts Member Services. If necessary, a replacement order will be mailed to you at no charge.

13-5 Ordering Refills through Mail-Service

A postage-paid envelope and reorder form will be included with each prescription you receive. To order a refill:

- Follow the instructions on the reorder form or call Express Scripts Member Services. Please have your charge card and prescription information handy if you call.

- Order refills two weeks before your current supply runs out. You will only be allowed to order the number of refills listed on your original prescription, so be sure to have your doctor issue a new prescription soon after you place your

last order. Prescriptions and refills are valid for 12 months. After that, your doctor must issue a new prescription.

13-6 Paying for Your Order

You may pay for prescriptions with a check or money order, or most major credit cards.

13-7 Questions

If you have questions about your medications, the shipment of medications, or if you need to order a refill, call Express Scripts Member Services.

13-8 Express Scripts Contact Information

Express Scripts Member Services can be reached at 1-800-440-0482 or on the web at www.express-scripts.com.

13-9 Procedure for Processing Claims and Filing Appeals

The procedure for processing retail and mail-service prescription drug claims and for filing appeals of denied claims is contained in Section 17.

Section 14 SUBROGATION AND REIMBURSEMENT RIGHTS

The Fund has the right to recover the full amount of benefit payments made to or on behalf of you or your eligible dependents (including your spouse and eligible dependent children) if:

- Some other party (third-party) caused the injury, illness or condition for which Fund payments were made (for example, you are injured by another driver in an automobile accident and the Fund made payments for medical treatment you received arising from injuries you sustained in that accident); or

- An insurance carrier or self-insured party ("insurer") including, but not limited to, an insurer that provides medical payments, uninsured or underinsured motor vehicle insurance, or worker's compensation insurance, is responsible for making payments for the medical bills or wage replacement benefits that the Fund paid (for example, you slip and fall on a job site and the Fund made payments for wages you lost as a result of your fall).

The Fund's right to recover is called "subrogation." The Fund's subrogation rights also apply to your estate or your dependent's estate in the event that the estate receives or benefits from payments from the Fund. The Fund has the right to be "reimbursed" or paid back those monies paid to you or on your behalf.

The Fund's subrogation right allows the Fund or the Plan Administrator to take legal action in your name against the third-party or insurer. If you (or your dependent) take legal action against the third-party, the Fund or the Plan Administrator may, but has no duty to, intervene in that legal action.

The Fund's subrogation right becomes a lien on the proceeds of any claim against the third-party or insurer for the full amount of Fund benefits paid. This means that the Fund has the right to receive, before you, the full amount of Fund benefits paid. This lien applies regardless of whether you assert the claim yourself (or as a co-claimant with others) or whether the Fund or the Plan Administrator asserts the claim in your name. This lien applies to the proceeds of any claim, regardless of whether the proceeds are recovered as a result of a lawsuit, settlement, compromise and release, or otherwise.

At the option of the Trustees, the Fund's lien will not be reduced by any costs involved in the recovery of the proceeds such as attorneys' or experts' fees, legal costs, or other out-of-pocket expenses; however, the Trustees may offset the Fund's lien by up to 25% of the claims paid on your, or your dependent's, behalf to account for your recovery costs (including attorneys' fees and litigation expenses). In addition, the Fund's lien will not be reduced by the failure of the recovery to make you (or your dependent) whole. For example, assume the Fund paid $50,000 for medical services you received in connection with injuries you sustained in a motor vehicle accident. You make a claim against the other driver for $125,000. Your $125,000 claim includes the $50,000 of medical expenses and $75,000 for lost wages. You recover $50,000. The Fund is

entitled to the entire $50,000.00 even though you did not recover the full amount of your claim.

If you (or your dependent) assert a claim against a third-party or insurer on your own behalf (or as a co-claimant with others) and monies are recovered from the third-party or insurer, it will be conclusively presumed that the recovery is subject to the Fund's subrogation right regardless of how the recovery is allocated among the claimants, and no matter whether the payments are characterized in the same manner as described by the Fund. For example, assume you filed a lawsuit against a third-party who caused injuries to you in a motor vehicle accident. The Fund made payments in the amount of $75,000.00 for your medical bills. You settle with the third-party for $125,000. The manner in which the settlement is structured allocates $75,000.00 of the settlement proceeds to lost wages, $50,000 to your spouse for loss of consortium, and allocates nothing to medical expenses. The Fund has the right to be reimbursed for the $75,000 of medical benefits paid despite the fact that the settlement allocated no amount to medical expenses.

If you (or your dependents) receive any recovery from a third-party or insurer, you are obligated to immediately and fully reimburse the Fund from the proceeds to the full extent of the dollar amount of Fund benefits that are payable or paid. If the proceeds are less that the amount paid by the Fund, the Fund has the right to receive the entire amount of the proceeds.

The Fund may appoint an agent for purposes of these subrogation and reimbursement rights.

By accepting benefits from the Fund, you and your dependents:

- Grant the Fund a lien on the proceeds of any payment, settlement or judgment that is secured relating to the injuries that caused such benefits to be provided;

- Agree to sign and deliver any documents necessary to secure the Fund's subrogation and reimbursement rights;

- Agree to notify the Fund promptly of a claim against or settlement with any third-party or any insurer for benefits paid or that may be paid under the Fund;

- Will cooperate with the Fund with regard to and take no action to jeopardize the Fund's subrogation and reimbursement rights.

Overpayments or Mistaken Payments

(1) In addition to, and without limiting those rights specified above under "Subrogation and Reimbursement Rights," the Fund has the right to recover from you, (or your dependent) any overpayments or mistaken benefit payments made to or on behalf of you (or your dependent), including but not limited to payment of such benefits pending approval or settlement of any workers' compensation benefits. The Plan Administrator may act as the Fund's agent for purposes of recovery of such over or mistaken payment.

(2) At the Plan Administrator's option, the Fund may also recoup such over or mistaken payments by: (1) reducing future payments due under the Fund to you (or your dependent) by the amount of such over or mistaken payment(s); and/or (2) by bringing a legal action to recover the over or mistaken payment(s).

Section 15 COORDINTION OF BENEFITS

Coordination of Benefits becomes a factor in paying for benefits when you have coverage under more than one health benefit program. The Coordination of Benefits provisions in this section apply to the following benefit programs described in this SPD:

Medical/Surgical Benefits
Major Medical Benefits
Dental Benefits
Optical Benefits
Retail and Mail-Service Prescription Drug Program

Note: Coordination of Benefits rules for Hospitalization Benefits are contained in the booklet provided by Highmark (see Section 6).

When you receive services covered under the Fund and another health benefit program, a determination will be made as to which program is "primary" and which is 'secondary". If this Plan's program is primary, benefits will be paid according to the terms of this Fund. If this Plan's program is secondary, any benefits paid by the primary program will be taken into account before a benefit determination is made under the Plan's program.

The determination of which program is primary and which is secondary is made as follows:

(1) If the other group health benefit program does not include a Coordination of Benefits provision, the other program will be primary.

(2) If the other group health benefit program includes a Coordination of Benefits program, the primary program will be determined in the following order:

(a) The program covering the employee will be considered primary.

(b) If both parents' programs cover the patient as a dependent child, the program of the parent whose birthday falls earlier in the calendar year will be primary. But, if both parents have the same birthday, the program which has covered the parent longer will be primary. However, if the parents are separated or divorced, the following will apply:

- The program which covers the child as a dependent of the parent with custody will be primary.
- If the parent with custody has remarried, the program which covers the child as a dependent of the stepparent with custody will be primary and the program covering the child as a dependent of the parent without custody will be secondary.

- Where there is a court decree which establishes financial responsibility for the health benefit expenses of the dependent child, the program which covers the child as a dependent of the parent with financial responsibility will be primary.

(c) Where the determination cannot be made in accordance with a. or b. above, the program which has covered the patient for the longer period of time will be primary provided that:

- The benefits of a program covering the person as an employee, other than a laid-off or retired employee, or as the dependent of such person, will be determined before the benefits of a program covering the person as laid-off or retired employee or as a dependent of such person; and

- If the other program does not have a provision regarding laid-off or retired employees, and, as a result, the benefits of each program are determined after the other, then the bullet point above will not apply.

(3) Services provided under any governmental program for which any periodic payment is made by or for you or your dependent will always be primary, except when prohibited by law including, but not limited to, when Medicare is required to be the secondary payer by law.

If it is determined that this plan's program is secondary, the Fund has the right to recover any expenses already paid in excess of their liability as the secondary program. You may be required to furnish information and to take any action necessary to assure the rights of the Fund.

16-1 Qualified Medical Child Support Orders

In accordance with federal law and the QMCSO Policies and Procedures applicable to this Fund, the Fund will honor a court order or administrative notice, including a National Medical Child Support Notice, requiring health coverage under the Fund for a child of a participant once the order or notice is determined by the Plan Administrator to be a Qualified Medical Child Support Order ("QMCSO"). Copies of the QMCSO Policies and Procedures are available upon request from the Fund Office.

16-2 Resolution of Disputes; Venue

Any and all disputes concerning the Plan or Fund shall be resolved exclusively in Allegheny County, Pennsylvania. The venue for any suit or cause of action arising out of the Plan shall be exclusively in the federal courts for the Western District of Pennsylvania or the state courts of Allegheny County, Pennsylvania.

Section 17 BENEFIT CLAIM PROCESSING AND APPEAL PROCEDURES

This Section 17 explains the deadlines for processing claims and the procedures for both filing and processing appeals of adverse benefit decisions under the following benefit programs offered through the Fund:

Death Benefits
Medical/Surgical Program
Major Medical Expense Program
Aetna-Meritain Health PPO Program
Dental Program
Optical Program
Retail and Mail-Service Prescription Drug Program

Note: The procedures for filing a claim for Death Benefits are described in Section 4. The procedures for filing a claim or obtaining benefits under the Major Medical Expense Program and Medical/Surgical Program are described in Section 9. The procedure for obtaining Aetna-Meritain Health PPO benefits is described in Section 10. The procedure for filing claims under the Dental Program is described in Section 11. The procedure for filing claims under the Optical Program is described in Section 12. **The procedure for filing claims and appeals under the Highmark Hospitalization Program is contained in the booklet provided by Highmark (see Section 6).**

17-1 Death Benefit Claim Processing

In most cases, a decision on payment of death benefits will be made by the claims administrator within 90 days of receipt of proof of death. If special circumstances require, the 90-day period may be extended for an additional 90 days. In such case, the claimant will be provided with a written notice of extension setting forth the reason for the extension and the date by which a decision is expected.

If a claimant is denied payment of the death benefit in full or in part, the claimant will receive a written explanation setting forth:

- the reasons for the denial;
- reference to pertinent Plan provisions for the denial;
- a description of any additional information that must be provided to support the claim and an explanation why it is necessary;
- an explanation of the appeal procedure for further review of the claim; and
- a statement of the claimant's right to bring a lawsuit under ERISA in the event of an adverse decision upon review of the denial.

17-2 Health Benefit Claim Processing

(a) Types of Claims

Claims for health benefits are categorized into three types for purposes of claim and appeal processing.

(1) Pre-Service Claim: A Pre-Service Claim is a claim for benefits, that is filed before the medical services or treatment is provided.

(2) Urgent-Care Claim: A Pre-Service claim may also be an Urgent-Care Claim. A Pre-Service claim is considered an Urgent-Care Claim if a delay in receiving the medical services or treatment for which the claim is made:

- could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- in the opinion of a physician with knowledge of the claimant's medical condition, could subject the claimant to severe pain that cannot be adequately managed without the services or treatment that is the subject of the claim.

A claim that constitutes an Urgent-Care Claim should include information on the medical circumstances that make it an Urgent-Care Claim. The determination of whether a claim for benefits is an Urgent-Care Claim is generally made by the claims administrator based on the information provided with respect to the claim.

If a physician with knowledge of the claimant's medical condition determines that the claim is an Urgent-Care Claim and the claim is filed as an Urgent-Care Claim, the claim will be processed as an Urgent-Care Claim for purposes of the claim and appeal procedures.

(3) Post-Service Claim: A Post-Service Claim is a claim for health benefits that is filed after medical services or treatment is provided. A Post-Service claim for health benefits may include Pre-Service Claims or Urgent-Care Claims where the medical services or treatment that was the subject of the Pre-Service Claim or Urgent-Care Claim has been provided and the only remaining issue with respect to such claim is the payment for the medical services or treatment.

(b) Processing Pre-Service Claims (Non-Urgent)

A Pre-Service Claim, including a request for pre-authorization, that requires no additional information to process will be approved or denied by the claims administrator no later than 15 days after receipt. Written or electronic notice of the approval or denial will be given to the claimant by the claims administrator in accordance with Section 17-2(f) or (g) below.

If special circumstances require, the initial 15-day period may be extended for up to an additional 15 days. The claims administrator will provide written or electronic notice of the extension to the claimant within the initial 15-day period. This notice will specify the circumstances requiring the extension and the date by which the claims administrator expects a decision.

If a claimant does not submit sufficient information, the claims administrator will provide the claimant with written or electronic notice of the specific information required to process the claim. Such notice will be provided before the end of the initial 15-day period, and the claimant will have **45 days** to provide the required information. In such case, the claims administrator will approve or deny the Pre-Service Claim no more than 15 days following the earlier of: (1) the date the claimant's response is received; or (2) the date such 45-day period ends.

(c) Processing Urgent-Care Claims

An Urgent-Care Claim that requires no additional information to process will be approved or denied by the claims administrator as soon as possible following receipt of the claim, but no later than **72 hours** after receipt. Oral, written or electronic notice of the approval or denial will be given to the claimant by the claims administrator in accordance with Section 17.2(f) or (g) below. If given orally, written or electronic notice will be sent within 3 days of the oral notification.

If a claimant does not submit sufficient information to allow the claims administrator to make a decision, the claims administrator will provide the claimant with oral, written or electronic notice of the specific information required to decide such claim. Such notice will be provided no later than **24 hours** after receipt by the claims administrator of the Urgent-Care Claim. The claimant will have a reasonable amount of time, but no less than **48 hours**, to provide the required information. The claims administrator will approve or deny the Urgent-Care Claim no later than **48 hours** following the receipt of the claimant's response or the end of the period for the claimant to provide the required information but no later than **48 hours** after the earlier of the receipt of such response or the end of such period.

(d) Processing Post-Service Claims

A Post-Service Claim that requires no additional information to process will be approved or denied by the claims administrator no later than 30 days after receipt. Written or electronic notice of the approval or denial will be given to the claimant by the claims administrator in accordance with Section 17-2 (f) or (g) below. If special circumstances require, the initial 30-day period to decide the Post-Service Claim may be extended for up to an additional 15 days. The claims administrator will provide written or electronic notice of such extension to the claimant before the end of the initial 30-day period. The notice will specify the circumstances requiring the extension and the date by which the claims administrator expects to decide the claim. If a claimant does not submit sufficient information to allow the claims administrator to decide a Post-Service Claim, the claims administrator will provide the claimant with written or electronic notice of the specific information required to decide the claim. Such notice shall be provided before the end of the initial 30-day period, and the claimant will have 45 days to provide the required information. The claims administrator will then approve or deny the Post-Service Claim no more than 15 days following the earlier of: (1) the date the claims administrator receives the claimant's response; or (2) the date such 45-day period ends.

(e) Extension of Time by Claimant

A claimant may voluntarily agree to extend any of the above periods for the claims administrator to make a decision on a claim for benefits.

(f) Approval of Claim

Other than the specific provision for oral notification of an Urgent-Care Claim, the claimant will be notified of the approval of a claim for benefits by the claims administrator via a written or electronic Explanation of Benefits Statement (EOB) that includes the following information:

- actual charges;
- amount paid; and
- the amount that is the claimant's responsibility.

When a claim is approved, the provider is paid directly unless payment was already made to the provider by the claimant, in which case the claimant will be reimbursed.

(g) Denial of Claim

Subject to oral notification provided for in Section 17-2(c) above with respect to an Urgent-Care Claim, the claimant will be notified of the denial, in whole or in part, of a claim for benefits by the claims administrator via a written or electronic Explanation of Benefits Statement (EOB) and an accompanying letter or statement that includes the following information:

- the reasons the claim was denied;
- reference to the plan provisions that caused the claim to be denied;
- a description of any additional information necessary to complete the claim and an explanation of why the information is necessary;
- any internal rule, guideline, protocol or other similar criterion that was relied on in the denial of the claim, or a statement that it was relied upon. A copy will be provided free of charge upon the claimant's request;
- if the denial of the claim was based upon medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the plan provisions to the claimant's medical circumstances, will be provided free of charge upon the claimant's request;
- an explanation of the appeal procedure, including applicable time limits, and for a denial of an Urgent-Care Claim, the expedited appeal procedure for an Urgent-Care Claim; and
- a statement of the claimant's right to bring a civil action under ERISA following an adverse determination upon appeal.

(h) Improperly Filed Claims

In certain instances, the claimant will be notified of the proper procedures to follow if the claimant failed to follow proper procedures in requesting pre-authorization or other Pre-Service claim. The claimant will be notified if someone who customarily handles matters for the Fund received an improperly filed communication that names a participant or dependent, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested. Notification will be provided within 5 days or within 24 hours if the communication constitutes an Urgent Care claim.

17-3 Appeals of Adverse Decisions

(a) Right of Appeal

(1) In General

A claimant has the right to appeal to the Board of Trustees any decision to deny a claim, any decision as to the amount of benefit paid, or any pre-authorization decision made by the claims administrator.

In connection with an appeal, the claimant is entitled to review all relevant documents and receive copies free of charge and to submit any comments, documents, records and information that support the claimant's claim for benefits.

(2) Appeal of Denial of Death Benefits

To appeal a denial of Death Benefits, the claimant must file a written request for a review of the decision to the Board of Trustees within **60 days** of receipt of the denial of the claim.

(3) Appeal of Urgent-Care Claim

In order to appeal a decision related to an Urgent-Care Claim, the claimant must submit an oral or written request for a review of the decision to the Board of Trustees within **180 days** of the date of receipt of the oral, written or electronic decision from the claims administrator.

(4) Appeal of Pre-Service (Non-Urgent) Claim or Post-Service Claim

In order to appeal a decision related to a Non-Urgent Pre-Service Claim or Post-Service Claim, the claimant must submit a written request for a review of the decision within **180 days** of the date of receipt of the decision to Board of Trustees.

17-4 Appeal Processing

(a) In General

A claim on appeal, regardless of type, shall be subject to a full and fair review by the Trustees of the Fund in accordance with the following:

- The review shall take into account all comments, documents, records and information submitted by the claimant in connection with the appeal, whether or not previously submitted or considered.

- The review shall not afford any deference to a prior determination on the claim, and it shall not be made by the individual who made the prior determination or by a subordinate of that individual.
- If the prior determination on the claim was based on a medical judgment, including a determination with regard to whether a particular treatment, drug or item is experimental, investigational or not medically necessary or appropriate, the review shall be made after consultation with a health care professional who has appropriate training and experience in the relevant field of medicine. Such health care professional shall not be an individual who was consulted with respect to the prior determination or a subordinate of that individual.
- The review shall provide for the identification of medical or vocational experts, if any, whose advice was obtained in connection with the claim that is the subject of the review, without regard to whether the advice was relied upon in making the prior determination on the claim.

(b) Processing Urgent-Care Claim Appeals

Any information regarding an appeal of an Urgent-Care Claim will be transmitted from the Board of Trustees to the claimant by telephone, facsimile or other similarly expeditious methods or transmission. The claimant will be provided with the same methods for the transmission of information to the Board of Trustees.

The Board of Trustees will review and make a decision on the appeal of a decision of an Urgent-Care Claim no later than **72 hours** after receipt of the claimant's request for appeal.

The decision by the Board of Trustees will be transmitted to the claimant by telephone, facsimile or other similarly expeditious methods of transmission. If given orally, written or electronic notice will be sent within 3 days of the oral notification.

(c) Processing Pre-Service (Non-Urgent) Claim Appeals

For an appeal of a decision on a Pre-Service Claim, a decision will be made no later than **30 days** after receipt.

The claimant will be provided with written or electronic notice of the decision on appeal by the Board of Trustees.

(d) Processing Death Benefit and Post-Service Claim Appeals

The Board of Trustees will make a decision on the appeal by the date of the first meeting of the Board of Trustees that follows receipt of the appeal, provided the Board of Trustees holds regularly scheduled meetings at least quarterly. However, if your appeal is received within the 30-day period preceding the date of the first meeting, the Board of Trustees will make its decision by the date of its second meeting that follows the receipt of your appeal. If special circumstances, such as the need to hold a hearing, require an extension, you will be notified of that extension, thus the Board of Trustees will make its decision by the date of its third meeting that follows the receipt of your appeal. In the event of an extension, you will receive

notification describing the special circumstances and the date by which a decision on your appeal is expected. The Board of Trustees issues its written decision on appeals within five days of the meeting at which the decision is made.

(e) Extension of Time by Claimant

A claimant may voluntarily agree to extend any of the above periods for the Board of Trustees to make a decision on appeal.

(f) Notice of Denial of Appeal

If a decision on appeal is adverse, the notice of the decision will include:

- The reasons for the decision.
- Reference to the plan provisions on which the decision was based.
- A statement of the claimant's right to review all relevant documents and to receive copies free of charge.
- For health claims:
  - any internal rule, guideline, protocol or other similar criterion that was relied on for the decision, or a statement that it was relied upon and a copy will be provided free of charge upon the claimant's request; and
  - if the decision was based upon medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision, applying the plan provisions to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon the claimant's request.
- A statement of the claimant's right to bring a civil action under ERISA.

(g) Final Decision

Decisions of the Board of Trustees are the final decision under the Fund.

17-5 Concurrent Care Decisions

(a) Reduction or Termination

If a previously approved ongoing course of treatment for a specified period of time or a specified number of treatments is reduced or terminated, the claims administrator will provide the covered person written or electronic notice of the reduction or termination sufficiently in advance of the reduction or termination in order to give the participant the opportunity to appeal and receive a decision on the appeal before the reduction or termination is effective.

(b) Requests for Extension of an Ongoing Course of Treatment

If the covered person requests an extension of a previously approved ongoing course of treatment for a specified period of time or a specified number of treatments, **and the request is made at least 24 hours before the end of the ongoing course of treatment and constitutes an Urgent Care claim**, the request will be approved or denied by the claims

administrator no later than **24 hours** after receipt. Oral, written or electronic notice of the approval or denial will be given to the participant in accordance with the claims processing rules of Section 17-2(f) or (g) above by the claims administrator. If given orally, written or electronic notice will be sent within 3 days of the oral notification.

If a covered person requests an extension of a previously approved ongoing course of treatment for a specified period of time or a specified number of treatments, and the request is an Urgent-Care Claim **that is not made at least 24 hours before the end of the ongoing course of treatment**, the request will be treated and processed as a new Urgent-Care Claim in accordance with the rules relating to Urgent-Care Claims.

If a participant requests an extension of a previously approved ongoing course of treatment for a specified period of time or a specified number of treatments, **and the request is not an Urgent-Care Claim**, the request will be treated and processed as a new Pre-Service Claim or new Post-Service Claim, as applicable.

17-6 Designation of Representative

A covered person may designate a duly authorized representative to act on his/her behalf in filing a claim for benefits and/or to appeal any denial of a claim for benefits. Such designation must be made in writing and should include the representative's name, address, telephone number, facsimile number, a statement indicating the extent of the representative's authority to pursue a claim and/or appeal, and an authorization to release medical information to the representative in a manner that complies with the requirements of law, including privacy regulations under the Health Insurance Portability and Accountability Act of 1996.

Notwithstanding above paragraph, if the claim for benefits or the appeal of a denied claim involves an Urgent-Care Claim, a health care professional with knowledge of the medical condition may act as the authorized representative of the claimant without the claimant's written designation. A health care professional for this purpose is a physician or other health care professional licensed, accredited or certified to perform health services under applicable state law.

17-7 Limitation Period for Legal Action to Recover Benefits.

No legal action can be taken against the Plan or the Fund more than three (3) years after a claim for benefits has been made by you or submitted on your behalf to a provider or insurance company for payment.

17-8 Questions

Any questions about claim and appeal procedures should be directed to the Fund Office.

Section 18 ERISA RIGHTS

As a participant in the Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Fund participants shall be entitled to:

Receive Information about Your Fund and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including any insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor.
- Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 group health plan coverage for yourself, your spouse or dependents if there is a loss of coverage under the Fund as a result of a qualifying event. You or your dependents must self-pay for such coverage. Review this summary plan description and the documents governing the Fund on the rules governing your COBRA continuation coverage rights.

Prudent Action by Fiduciaries

In addition to creating rights for Fund participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called 'fiduciaries', have a duty to do so prudently and in the interest of you and other Fund participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Fund review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Fund and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child

support order, you may file suit in federal court. If it should happen that Fund fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Questions

If you have any questions about the Fund 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.