Account Login
The Health and Welfare Plan
Part I: About The Health & Welfare Plan
Part II: Plan Description and FAQs
Part III: Plan Document
Amendments
Board of Trustees
What's New
Schedule of Benefits
Summary Annual Report
Grandfather Status
Summary of Benefits & Coverage
Contact the Health & Welfare Plan
WHCRA Notice
Online Enrollment

< Back

You are here > Health & Welfare Plan > The Health and Welfare Plan > Part III: Plan Document

Part III: Plan Document

Section 1: Definitions	Section 2: Eligibility	Section 3: Beneficiaries	Section 4: Benefit Classifications	Section 5: Death Benefits
Section 6: Benefits for Non Occupational Accidental Death and Dismemberment	Section 7: Survivor Death Benefits	Section 8: Weekly Accident & Sickness Benefits	Section 9: Medical Program	Section 10: Maternity
Section 11: Vision Care Benefits	Section 12: Dental Expense Benefits	Section 13: Prescription Drug Benefits	Section 14: Extension of Benefits During Period of Disability	Section 15: Continuation of Coverage for Medical, Vision, Dental and
Section 16: Time Limit for Filing Claims	Section 17: Claims Review and AppealProcedures - Claims for Medical Benefits	Section 18: Claims Review and Appeal Procedures - Claims forBenefits Other than Medical	Section 19: Authority of Trustees	Section 20: Coordination of Benefits
Section 21: Multiple Employment	Section 22: Subrogation	Section 23:General Exclusions & Limitations	Section 24:Family & Medical Leave	Section 25:Assignment of Benefits

SECTION 1. DEFINITIONS

1.01 **Agreement and Declaration of Trust.** The term "Agreement and Declaration of Trust" as used herein shall mean the Agreement and Declaration of Trust entered into as of July 1, 1971 establishing the ITPEU Health and Welfare Fund, including any amendments hereto or modifications thereof.

1.02 **Beneficiary.** The term "Beneficiary" as used herein shall mean any person, who is receiving or entitled to receive benefits from the Plan because of designation for such benefits by a Participant or because of the provisions of the Plan.

1.03 **Claims Administrator.** The term "Claims Administrator" shall refer to a business entity which has been engaged by the Trustees to administer all medical benefit claims.

1.04 **Collective Bargaining Agreement.** The term "Collective Bargaining Agreement" or "CBA" shall mean any collective bargaining agreement now or hereafter in effect between any Employer

and the Union which provides for contributions by such Employer to the Health and Welfare Fund.

1.05 **Contributions.** The term "Contributions" shall mean the payments required to be made to the Fund by an Employer pursuant to a Collective Bargaining Agreement or applicable Federal Law.

1.06 **Covered Family Member.** The term "**Covered Family Member**" shall mean any of the following:

A. The Spouse of an Employee provided that a person shall not be considered a Spouse of an Employee if that person is either divorced from the Employee, legally separated from the Employee or has not resided with the Employee for one year or more prior to the date any benefit specified in this Plan becomes due.

B. A child of an Employee, or for whom an Employee has been appointed legal guardian or custodian by a court of competent authority, from date of birth to the age of 26.

C. A child of an Employee, or for whom an Employee has been appointed legal guardian or custodian by a court of competent authority, regardless of age, who is incapable of self support because of physical and/or developmental disability, and who is dependent upon the Employee for support. Such a child shall be eligible for Covered Family Member benefits provided that he or she became a Covered Family Member under this Plan and his or her incapacity began before he or she reached the age of 26 years. Proof of such a child's incapacity may be required by the Board of Trustees no later than 31 days after the child reaches the age limit in question. Proof of the continued existence of such incapacity may be required by the Board of Trustees from time to time.

D. The term "Covered Child" shall include all persons specified in Subsections B and C hereof, and any step-child of an Employee for whom coverage was provided by the Plan prior to December 31, 2010. It shall not include step-children who are not covered by the Plan as of December 31, 2010. It shall not include step-children who were not covered by the Plan during the period December 31, 2010 through December 31, 2015. Effective January 1, 2016 the term "Covered Child" shall include all persons specified in Subsections B and C hereof, who are step-children of an Employee, provided that the Employee provides such proof of step-child status as required by the Fund Office.

1.07 **Deductible.** The term "Deductible" shall refer to the amount of a Participant's medical expenses or dental expenses that must be paid by the Participant in a calendar year before the balance of his or her medical expenses (In-Network and Out-of-Network) or dental expenses become covered medical or dental expenses. The amount of a Participant's Deductible is specified in the Schedule of Benefits.

1.08 **Employee.** The term "Employee" or "Employees" shall mean such Employees on whose behalf an Employer has so agreed to make contributions to the Health and Welfare Fund, and shall also include such Employer Trustees who submit contributions to the Fund on behalf of themselves and who have agreed in writing to be bound by the terms and conditions of the Agreement and Declaration of Trust, this Plan document and any Amendments thereto.

1.09 **Employer.** The term "Employer" or "Employers" shall mean any Employer who is, or who hereafter becomes, obligated to contribute to the Health and Welfare Fund pursuant to the terms of a Collective Bargaining Agreement, or other written instrument, with the Union, and shall also include the Union when it is contributing to the Fund on behalf of any of its Employees.

1.10 **Health and Welfare Fund.** The term "Health and Welfare Fund" or "Fund" shall mean the ITPEU Health and Welfare Fund, comprising this Plan, the Agreement and Declaration of Trust referred to in Section 1.01 hereof, and the Collective Bargaining Agreements referred to in Section 1.04hereof.

1.11 **Health Care Provider.** The term "Health Care Provider" means an individual who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Health Care Providers include, but are not limited to, Physicians and physical therapists. Registered nurses and licensed practical nurses shall not be considered Health Care Providers under this document.

1.12 **Hospital.** The term "Hospital shall mean a legally established institution which is licensed as a hospital under the laws of the State where the hospital is located, which is open at all times and which is operated primarily for the care and treatment of sick and injured persons as in-patients, which has a staff of one or more licensed physicians available at all times, which continuously provides 24 hour nursing service by graduate registered nurses, which provides organized facilities

for diagnosis and major surgery and which is not primarily a clinic, nursing, rest or convalescence home, or similar establishment. A psychiatric hospital duly licensed by the State in question shall be considered a hospital.

1.13 **Incurred.** A claim shall be considered "incurred" under the following circumstances:

A. A claim for hospital benefits is incurred on the date the Employee or Covered Family Member enters a hospital;

B. A claim for weekly accident and sickness benefit is incurred on the first date of disability if it is caused by an accident, or on the fourth day of disability if it is brought about by illness;

C. A claim for death benefits or accidental death or dismemberment benefits is incurred on the date of death or dismemberment;

D. Any other claim for benefits is incurred on the date the service in question is rendered.

1.14 **In-Network Expenses.** The terms "In-Network Expenses" or "PPO Network Expenses" refer to all medical expenses incurred as a result of treatment or care by Hospitals and Health Care Providers who are affiliated with the Network of Health Care Providers offered by the Preferred Provider Organization with whom the Plan has contracted.

1.15 **Installation.** The term "Installation" shall mean allfacilities covered by a Collective Bargaining Agreement (and Service Contract when pertinent) regardless of geographical location.

1.16 **Maximum Medical Benefit.** The term "Maximum Medical Benefit" or "Maximum Major Medical Benefit" shall refer to the maximum amount that the Fund shall pay each calendar year for combined In-Network and Out-of-Network medical benefits per Participant as specified in the Schedule of Benefits for such Participant.

1.17 **Mental Health Disorder.** The term "Mental Health Disorder" includes mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. As used in this Plan, the term "Mental Health Disorder" does not include any condition related to drug, alcohol or chemical dependency.

1.18 **Network.** The term "Network" shall refer to those Hospitals and Health Care Providers who have contracted with the Preferred Provider Organization to provide medical services for Plan Participants at predetermined fees.

1.19 **Out-of-Network Expenses.** The term "Out-of-Network Expenses" refers to all medical expenses incurred as a result of treatment or care by Hospitals and Healthcare Providers who are not affiliated with the Network of Healthcare Providers offered by the Preferred Provider Organization with whom the Plan has contracted.

1.20 **Out Of Pocket Maximum.** The term "Out Of Pocket Maximum" shall refer to a Participant's maximum payment responsibility and family maximum payment responsibility under the Plan's Medical Benefit Program (plus the Deductible). The amount of a Participant's individual and family maximum payment responsibility is specified in the Schedule of Benefits.

1.21 **Participant.** The term "Participant" shall mean any Employee who is qualified for participation in the Plan in accordance with the provisions hereinafter set forth, and remains a Participant thereof, and any "Covered Family Member" as defined at Section 1.06 hereof.

1.22 **Physician.** The term "Physician" means a licensed medical practitioner, including a clinical psychologist, who is practicing within the scope of his or her license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where he or she practices provided he or she is:

- Operating within the scope of his or her license; and
- Performing a service for which benefits are provided under this Plan when performed by a Physician.

1.23 **Plan.** The term "Plan" as used herein shall mean the rules and regulations hereinafter set forth.

1.24 **Preferred Provider Organization (PPO).** The term "Preferred Provider Organization" or "(PPO)" shall refer to the organization with whom the Plan has contracted to provide medical services by making available a network of health care providers who have entered into a contract with such PPO to provide medical services to Plan Participants at predetermined fees as negotiated between the PPO and the health care providers.

1.25 **Primary Care Physician.** The term "Primary Care Physician" shall mean a General Practitioner, Internist, Family Practice Physician or Pediatrician.

1.26 **Schedule of Benefits.** The term "Schedule of Benefits" shall mean the various Schedules of Benefits, and all Supplements and Amendments thereto, set forth in the Summary Plan Description.

1.27 **Trustees.** The term "Trustees" as used herein shall mean the Board of Trustees established by the Agreement and Declaration of Trust and the persons who at any time are acting in such capacity pursuant to the provisions of that Agreement.

1.28 **Union.** The term "Union" shall mean the Industrial, Technical and Professional Employees Union, AFL-CIO, and any designated affiliate thereof.

SECTION 2. ELIGIBILITY AND PARTICIPATION

2.01 **Filing of Enrollment Card.** A Present Employee is eligible for Benefit Coverage upon his Employer's agreement in writing to be bound by the terms and conditions of the Agreement and Declaration of Trust. In order to determine Eligibility for Benefits, the Employee or Covered Family Member must completely fill out a Plan enrollment card and file such card with the Fund Office . An Employee may file his or her enrollment card by submitting such card to his or her Shop Steward, Union Representative or Employer for transmittal to the Fund Office. Future Employees are eligible for Benefit Coverage effective January 1, 2015 on the 31st day after the first day of such employment. If the Employee fills out a Fund Enrollment Form and files it with the Fund Office more than 30 days after the date the Employee becomes eligible or the date family or marital status changes, coverage will retroactively by provided on receipt by the Fund office of the completed enrollment card/; but benefit coverage will not be retroactive for more than 30 days before the Fund receives notification.

2.02 **Date of Participation - Present Employees.** Each present Employee of an Employer, who has filed an enrollment card as specified in Section 2.01, shall become a Participant in the Plan on the date that his Employer agrees in writing to be bound by the terms and conditions of the Agreement and Declaration of Trust. In the event such Employee is on leave of absence at the time his or her Employer agrees in writing to be bound by the terms and provisions of this Plan, eligibility for benefits shall not commence until such Employee returns to active work.

2.03 **Date of Participation - Future Employees.** Each Employee, who has filed an enrollment card as specified in Section 2.01, and who enters into the service of an Employer after the date on which such Employer agrees to be bound by the terms and provisions of the Agreement and Declaration of Trust shall become a Participant in the Plan on the 91stday after the first day of such employment.

2.04 **Special Eligibility Provision for Certain Dental Benefits.** No Employee or Covered Family Member shall be eligible for benefits under this Plan for prosthetics (bridges, partials or complete dentures, and space maintainers, including adjustment and repair thereto) unless the Employee has been a Participant in the Plan for twelve (12) consecutive months.

2.05 **Loss of Eligibility.**

(a) An Employee and his or her Covered Family Members' eligibility for benefits shall terminate on the date such Employee leaves the employment of an Employer or the Board of Trustees terminates the Fund, whichever happens first. If an Employer's contributions for an Employee are delinquent for a one month period, the eligibility of such Employee and his or her Covered Family Members for benefits for any claim incurred after a period of 40 or more days from the commencement of such delinquency shall be suspended until such time as the Employer is no longer delinquent for one or more months. During the period of suspension, all claims incurred by such Employee and his or her Covered Family Members shall be held in abeyance until such time as the delinquent contributions are paid. All such claims shall be promptly processed by the Fund as soon as the Employer is no longer delinquent for one or more months. No later than 10 days after the contributions were due,

the Fund shall send written Notice to the Employees of the delinquent Employer, informing them that payment of their benefits, and the benefits of their covered family members, will be suspended in 30 days due to lack of payment by their Employer unless the Employer pays off the delinquency within that 30 day period. Such Notice shall state the actual date of such suspension. Copies of such Notice shall be sent to the Employer, and the applicable Contracting Officer and DOL Wage& Hour Area Director. In addition, a separate letter, with copies to the Employer and affected Employees, will be sent by the Fund to the applicable Contracting Officer and Wage & Hour Area Director, advising of the delinquency and resulting suspensions of benefits.

(b) Coverage of an eligible child terminates automatically when the child attains 26 years of age. Coverage of a disabled child over 26ceases if the child is found to be no longer totally permanently disabled. Coverage of the spouse of an Employee terminates automatically as of the date of divorce or death. Coverage of all Covered Family Members of an Employee terminates automatically as of the date of death of the Employee.

2.06 **Time That Claim is Incurred.** The Plan shall pay benefits for eligible Employees and their eligible Covered Family Members for all claims incurred during a period of eligibility. A claim shall be considered "incurred" under the following circumstances:

A. A claim for hospital benefits is incurred on the date the Employee or Covered Family Member enters a hospital;

B. A claim for weekly accident and sickness benefit is incurred on the first date of disability if it is caused by a non-job related accident or on the fourth day of disability if it is brought about by a non-job related illness;

C. A claim for death benefits or accidental death or dismemberment benefits is incurred on the date of death or dismemberment;

D. Any other claim for benefits is incurred on the date the service in question is rendered.

E. In case of fraud or attempted fraud upon the Fund, the Board of Trustees may, in its discretion, cease benefit payments until the matter is resolved. In the case where an Employee has received funds by reason of a fraud, such Employee and or his/her Covered Family Members shall not be entitled to further payment of benefits until the amount of monies improperly and fraudulently received from the Fund shall have been repaid to the Fund.

SECTION 3. BENEFICIARIES

3.01 **Right to Designate a Beneficiary.** Each Employee shall have a right to designate a beneficiary (or beneficiaries) to receive any benefits hereunder payable by reason of the Employee's death.

3.02 **Form of Designation of Beneficiary.** A beneficiary designation shall not be valid unless it is in writing on a form supplied for that purpose by the Trustees. The said designation of beneficiary form shall not be valid unless it is on file at the principal office of the Fund.

3.03 **Change of Beneficiary.** An Employee may from time to time revoke or change any designation of beneficiary or beneficiaries by completing and filing a new beneficiary form in the principal office of the Fund.

3.04 **Allocation of Shares to More Than One Beneficiary.** If more than one beneficiary is validly designated, and in such designation the Employee has failed to specify their respective interests, each beneficiary that survives the Employee shall share equally in the benefit in question.

3.05 **No Beneficiary.** If the beneficiary of record cannot be located within six (6) years after the Employee's date of death, or if there is no beneficiary at the death of the Employee because no beneficiary of record survives the Employee, or because no beneficiary has been designated, then benefits shall be payable in accordance with the following provisions:

A. Any amount payable by reason of the death of an Employee shall be paid as follows:

1. 100% to any surviving spouse;

2. If there is no surviving spouse, the benefits will be divided equally by any surviving children;

3. If there is no surviving spouse or children, the benefits will be divided equally among the

surviving parents;

4. If there are no surviving spouse, children or parents, benefits will be divided equally among surviving brothers and sisters;

5. If there are no surviving spouse, children, parents or brothers or sisters, the benefits will be paid to the Executor or Administrator of the Employee's Estate.

As used in this Section 3.05 the term "Children" includes a posthumous child, a child legally adopted by the Employee or a step-child who is claimed by the Employee as a deduction on his or her federal income tax return.

B. Any non-death benefit which has accrued prior to the death of the Employee may be paid by the Board of Trustees, in their discretion, to the Estate of the Employee, in accordance with the provisions of Section 3.05 (A) or to any other person who is an object of the natural bounty of the Employee.

C. If payment is made according to the foregoing provisions, the Board of Trustees shall be completely discharged as to liability therefore.

3.06 **Minor or Incompetent Beneficiary.** If any beneficiary designated in accordance with this Section 3 is a minor or is otherwise incapable of giving a valid release for any payment due, any benefits to such beneficiary shall be paid to the duly appointed Guardian or Committee of such beneficiary. If there is no such Guardian or Committee appointed, the Trustees may, at their discretion, make payment of the amount of the benefit to such beneficiary to any relative by blood or connection by marriage of such beneficiary, or to any other person or institution appearing to them to have assumed custody and principal support of such beneficiary, for the sole benefit of such beneficiary. In such event, the Trustees may pay the benefit due at such monthly rate as they deem appropriate. Such payment shall constitute a full discharge of the obligations of the Board of Trustees to the extent thereof.

3.07 **Prohibited Beneficiaries.** A Participant may not designate a management representative or supervisory employee of his Employer as his beneficiary unless such beneficiary is related to the Participant. The Trustees, in their sole discretion, shall have authority to determine whether or not a sufficient relationship exists between such a beneficiary and the Participant in order to warrant payment of death benefits to such beneficiary.

SECTION 4. BENEFIT CLASSIFICATION

4.01 **Benefit Classification.** The Fund shall establish four (4) levels of benefit classification. These benefit levels shall be based on the average number of hours an Employee works per week for which contributions are received. In order to determine an Employee’s average number of hours worked per week the Fund shall review the number of hours worked by such Employee in the prior 90 day period. The highest level of benefits shall be paid to Employees and their Covered Family Members who are in Level IV with the lowest level of benefits being available to Employees and their Covered Family Members who are in Level I.

4.02 **Classification Levels.** The four levels of benefits provided by the Plan shall be classified as follows:

Classification	Weekly Hours Worked
I	Less than 12 hours per week
II	12 through 19 hours per week
III	20 through 29 hours per week
IV	30 hours or more per week

SECTION 5. DEATH BENEFITS

5.01 **Benefits in Event of Death of Employee.** Upon receipt of due proof at the principal office of the Fund of the death of an Employee from any cause which occurs during a period of his or her eligibility or within 31 days after the termination of such eligibility, the Fund shall pay to the

beneficiary the amount of Death Benefit specified hereunder in accordance with the Schedule of Benefits.

5.02 **Continuation of Death Benefit Coverage in the Event of Total and Permanent Disability.** If an Employee becomes totally and permanently disabled while eligible for benefits, his or her eligibility for Death Benefits will, without payment of further contributions, remain in force for two years, or for the length of time equal to such Employee's service with his or her Employer if such service was for less than two years.

5.03 **Benefits in Event of Death of Covered Family Member.** In the event of the death of a Covered Family Member from any cause during a period when an Employee is eligible for benefits, the Employee shall receive from the Plan the full amount specified hereunder in the Schedule of Benefits. An Employee's eligibility for Covered Family Member Death Benefits terminates upon loss of employment with an Employer covered by this Plan or the death of the Employee.

5.04 **Payment of Death Benefits in the Event Employee is Single.** Those Employees who are single at the time of their death and are otherwise eligible for benefits shall have an additional $1,000.00 in Death Benefits added to the amount of the Death Benefit as provided in the Schedule of Benefits.

SECTION 6. BENEFITS FOR NON-OCCUPATIONAL ACCIDENTAL DEATH AND DISMEMBERMENT

6.01 **Payment of Accidental Death and Dismemberment Benefits.** If an Employee, while eligible for benefits hereunder, suffers any of the losses described in this Section 6 as a result of bodily injuries caused solely through external, violent and accidental means, directly and independently of all other causes, and the loss occurs within ninety (90) days from the date of such injuries, the Fund shall pay to the Employee, if living, otherwise to the beneficiary, the benefit amount specified for such loss in Section 6.02 provided, however, that no payment shall be made under this Section for any loss caused wholly or partly, directly or indirectly by:

A. Suicide or self-inflicted injuries;

B. Declared or undeclared war or act of war;

C. Commission of a crime by the Employee;

D. Travel or flight, including getting in or out, on or off, any aircraft, or device which can fly above the earth’s surface, except as a passenger on a regular commercial airliner;

E. Sickness, disease or bodily infirmity;

F. Injury or death for which the Employee is entitled to benefits under any worker’s compensation or occupational disease law;

G. Voluntary self-administration of any drug or chemical substance not prescribed and taken according to the directions of a licensed physician. (Accidental ingestion of a poisonous substance is not excluded);

H. Riding or driving in any kind of a race.

6.02 **Schedule of Accidental Death and Dismemberment Benefits.**

A. In the event of the accidental death of an Employee as described in Section 6.01 hereof, the Fund shall pay 100% of the benefit amount specified in the Schedule of Benefits to the beneficiary or beneficiaries of the Employee.

B. **Dismemberment**

(1) The term "Dismemberment" shall mean the loss of one or both hands at or above the wrist, the loss of one or both feet at or above the ankle joint or the total and unrecoverable loss of sight in one or both eyes.

(2) The Fund shall pay the Employee 100% of the amount specified in the Schedule of Benefits in the event such Employee, during a period of eligibility, suffers the following losses by external, violent and accidental means as described in Section 6.01 hereof:

Both Feet	One Hand and Sight of One Eye
Both Hands	One Foot and Sight of One Eye
One Hand and One Foot	Sight of Both Eyes

C. One-half of the benefit set forth in the Schedule of Benefits shall be paid to an eligible Employee who suffers any of the following types of losses as a result of external, violent and accidental means as described in Section 6.01 hereof:

Loss of one hand, Loss of one foot, Sight of one eye.

D. In no event will more than the full amount specified in the appropriate Schedule of Benefits hereof be paid for losses resulting from one accident.

SECTION 7. SURVIVOR DEATH BENEFITS

7.01 **Payment of Survivor Death Benefits.** In addition to the Death Benefits previously described herein, the Fund shall pay a Survivor Death Benefit in monthly installments to the beneficiary or beneficiaries of an Employee who dies from any cause at any time or place during a period of eligibility for benefits. The amount of each monthly installment and the period of time over which such installments shall be paid is set forth at the Schedule of Benefits.

SECTION 8. WEEKLY ACCIDENT AND SICKNESS BENEFITS

8.01 **Payment of Weekly Accident and Sickness Benefit.** The Fund shall pay an Employee a weekly benefit during the period of time that such Employee is disabled from employment provided that such Employee is under the care of a duly licensed physician and his or her disability results from a non-job related accident, sickness or disease for which benefits are not payable under any worker's compensation law or occupational disease law or any law or policy of insurance providing for the payment of motor vehicle "No-Fault" or First-Party Benefits.

8.02 **Amount of Benefit.** The amount of the weekly benefit payable hereunder shall be the benefit for each Classification Level specified in the Schedule of Benefits.

8.03 **Waiting Period.** Eligibility for weekly accident and sickness benefit commences on the first day of disability if the Employee is disabled as a result of an accident and on the fourth day of disability if the Employee is disabled as a result of sickness.

8.04 **Duration of Benefits.** Weekly accident and sickness benefits shall continue for a maximum of 26 weeks for any one disability. Effective July 1, 2017, the weekly accident and sickness benefit will be reduced to coverage of a maximum of six (6) weeks for any one disability. Participants who were receiving weekly benefits prior to July 1, 2017, will only be eligible to receive up to an additional six (6) weeks beginning July 1, 2017.

8.05 **Separate Periods of Disability.** Weekly accident and sickness benefits shall be paid for as many separate and distinct periods of disability as may occur. When benefits have been paid for the maximum number of weeks, coverage shall terminate. However, an Employee will again be eligible for this coverage as soon as he or she has returned to active work and has completed two weeks of continuous active service. If an Employee recovers from a disability for which less than the maximum number of weeks has been paid and again becomes disabled after less than two weeks of active work on a full-time basis, both disabilities shall be considered as one period of disability unless the second period of disability is due to injury or sickness which is entirely unrelated to the cause of the previous disability and begins after return to active work on a full-time basis.

SECTION 9. MEDICAL PROGRAM

9.01 **Extent Of Coverage**. The Medical Program provided by the Fund covers reasonable and necessary medical expenses. It does not apply to the Dental, Vision or Welfare benefits provided by the Fund. Nor does it apply to any medical expenses specifically excluded from coverage in other portions of this Plan Document.

9.02 **Medical Benefits.**

(a) **Deductible.** Each Participant shall be responsible for a Deductible as defined at Section 1.05. This Deductible applies to each Participant during a calendar year, regardless of the number of injuries or illnesses such Participant may have.

(b) **Maximum Deductibles Per Family.** There will be a maximum of two (2) Deductibles per family per calendar year, regardless of the size of the family.

(c) **Amount of Medical Benefit (In-Network Expenses).** For In-Network Expenses the Fund shall pay 70% of all covered medical expenses per eligible Participant per calendar year in excess of the Deductible. This 70% payment by the Fund shall be paid until the Participant's Out Of Pocket Maximum has been met or the Participant's maximum calendar year benefit has been paid, whichever comes first. In the event the Participant's Out Of Pocket Maximum has been met and the annual Maximum Medical Benefit has not been fully paid, the balance of all covered medical expenses for the year will be paid at 100% up to the annual Maximum Medical Benefit as specified in the pertinent Schedule of Benefits.

(d) **Amount of Medical Benefit (Out-of-Network Expenses).** For Out-of-Network Expenses the Fund shall pay 60% of all covered medical expenses per eligible Participant per calendar year in excess of the Deductible. This 60% payment by the Fund shall be paid until the Participant's Out Of Pocket Maximum has been met or the Participant's maximum calendar year benefit has been paid, whichever comes first. In the event the Participant's Out Of Pocket Maximum has been met and the Maximum Medical Benefit has not been fully paid, the balance of all covered medical expenses for the year will be paid at 100% up to the Maximum Medical Benefit as specified in the pertinent Schedule of Benefits.

(e) **Amount of Maximum Medical Benefit.** The out of pocket Maximum Medical Benefit is combined for In and Out of Network expenses each calendar year. The calendar year Maximum Medical Benefit shall include all benefits paid at 60% and 70%, plus all benefits paid at 100%.

(f) **Participant's Responsibility.** In addition to the Deductible specified in Section 9.02(a) hereof, each Participant is responsible for the 30% of In-Network covered medical expenses and the 40% of Out-of-Network covered medical expenses (up to the Participant's Out of Pocket Maximum as defined at Section 1.20 hereof). All medical expenses in excess of the Participant's Maximum Medical Benefit as specified in the pertinent Schedule of Benefits for the calendar year in question shall be the Participant's responsibility.

(g) **Special Rule for Participants in Class III and IV Whose Contribution Rates are ~~$3.24~~ $3.75/Hour or Higher, and Participants in Class I and II Whose Contribution Rates are $4.00/Hour or Higher.** Notwithstanding any other provision of this Plan to the contrary, for eligible Participants in Class III and IV whose contribution rates are ~~$3.24~~ $3.75/hour or higher, and eligible Participants in Class I and II whose contribution rates are $4.00/hour or higher, a system of co-pays shall be in effect for In-Network physician visits and In-Office testing. For all In-Network office visits with Primary Care Physicians and all tests/diagnostic procedures performed in such physicians' offices, the Participant shall pay the amount of the co-pay specified in his or her Schedule of Benefits and the Plan shall pay 100% of the balance. The term "Primary Care Physician" means a general practitioner, internist, family practice physician or pediatrician. For all In-Network physician visits to specialists, and all tests/diagnostic procedures performed in such specialists' offices, the Participant shall pay the amount of the co-pay specified in his or her Schedule of Benefits and the Plan shall pay 100% of the balance. No deductible shall be applicable to such physicians' visits or In-Office testing.

(h) **Annual Renewal of Medical Benefits.** Except as provided at Section 9.03(b)(19), dealing with Hearing Aid Benefits, medical benefits provided by the fund shall renew each calendar year.

9.03 **Covered Medical Expenses**.

(a) **Definition of "Covered Medical Expenses"**. The term "Covered Medical Expenses" means the medical expenses incurred by or on behalf of a Participant for the charges listed in Section 9.03(b), if they are incurred after he or she becomes eligible for these benefits. Expenses incurred for such charges are considered Covered Medical Expenses to the extent that the services or supplies provided are prescribed and/or recommended by a Physician, and are Medically Necessary for the care and treatment of an injury or illness and the charges are reasonable in light of charges for similar services in the community in question.

(b) **Covered Charges**. The following charges shall be considered "Covered Medical Expenses" provided the requirements of Section 9.03(a) are met and subject to the limitations on preventive care services set forth in Section 9.03(c).

1. **Hospital In-Patient Service-**Charges made by a Hospital for non-mental health disorders, on its own behalf, for room and board at semi-private room rate, ICU/CCU charges, general nursing care and other necessary services and supplies, provided, that if the Hospital only has private rooms, Covered Charges shall be based on the Hospital's prevailing room rate;

2. **Ambulance Services-**Charges for licensed ambulance service to or from the nearest Hospital where the needed medical treatment can be provided. Air ambulance is covered subject to Medical Necessity;

3. **Hospital Out Patient Services**-Charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient;

4. **Free-Standing Surgical Facility Services-**Charges made by a free-standing surgical facility, on its own behalf, for medical care and treatment;

5. **Rehabilitation Hospital and Subacute Facility Services**-Charges made by a Rehabilitation Hospital or a subacute facility, on its own behalf, for medical care and treatment, provided that such medical care and treatment is associated with a prior hospitalization and, provided further, that the Fund shall pay for no more than ten (10) days of such medical care and treatment at a Rehabilitation Hospital or subacute facility;

6. **Physicians' Services-**Charges made by a Physician for professional services;

7. **Anesthetics, Chemotherapy Services, Etc.-**Charges made for anesthetics and their administration; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gasses and their administration; prosthetic appliances; and dressings;

8. **TMJ-**Charges made for surgical and non-surgical care of Temporomandibular Joint Dysfunction (TMJ), up to a lifetime maximum of $15,000;

9. **Laboratory, Radiation Services, Etc.-**Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic and radiological procedures;

10. **Organ Transplant Services**:

A transplant means a procedure or series of procedures by which an organ or tissue is either:

- removed from the body of one person (called a "donor") and implanted in the body of another person (called a "recipient"); or
- removed from and replaced in the same person's body (called a "self-donor")

A covered transplant means a medically appropriate transplant of one of the following organs or tissues only and no others.

- Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver or small bowel/liver, kidney, pancreas or kidney and pancreas when transplanted together in the same operative session.

- Autologous (self-donor) bone marrow transplants with high doses of chemotherapy is considered eligible for coverage on a prior approval basis, but only if required in the treatment of:

- Non-Hodgkin's lymphoma, intermediate or high grade Stage III or IVB;
- Hodgkin's disease (lymphoma), Stages IIIA, IIIB, IVA, or IVB;
- Neuroblastoma, Stage III or Stage IV;
- Acute lymphocytic or nonlymphocytic leukemia patients in first or subsequent remission, who are at high risk for relapse and who do not have an HLA-compatible donor available for allogenic bone marrow support;
- Germ cell tumors (e.g., testicular, mediastinal, retroperitoneal, ovarian) that are refractory to standard doses of chemotherapy, with FDA-approved platinum compounds;
- Metastatic breast cancer that (a) has not been previously treated with systemic therapy, (b) is currently responsive to primary systemic therapy, or (c) has relapsed following response to first-line treatment;
- Newly diagnosed or responsive multiple myeloma, previously untreated disease, those in a

complete or partial remission, or those in a responsive relapse.
- Homogenic/allogenic (other donor) or syngeneic hematopoietic stem cells whether harvested from bone marrow peripheral blood or from any other source, but only if required in the treatment of:
  - aplastic anemia;
  - acute leukemia;
  - severe combined immunodeficiency exclusive of acquired immune defiency syndrome (AIDS);
  - infantile malignant osteoporosis;
  - chronic myelogenous leukemia;
  - lymphoma (Wiscott-Aldrich syndrome);
  - lysosomal storage disorder;
  - myelodysplastic syndrome.

"Donor Costs" means all costs, direct and indirect (including administration costs), incurred in connection with:

- medical services required to remove the organ or tissue from either the donor's or the self-donor's body;
- preserving it; and
- transporting it to the site where the transplant is performed.

In treatment of cancer, the term "transplant" includes any chemotherapy and related courses of treatment which the transplant supports.

For purposes of this benefit, the term "transplant" does not include transplant of blood or blood derivatives (except hematopoietic stem cells) which will be considered as non-transplant related under the terms of the Plan.

"Facility Transplant" means all Medically Necessary services and supplies provided by a health care facility in connection with a covered transplant except donor costs and anti-rejection drugs.

"Medically Appropriate" means the recipient or self-donor meets the criteria for a transplant established by the Plan.

"Professional Provider Transplant Services" means all Medically Necessary services and supplies provided by a professional provider in connection with a covered transplant except donor costs and anti-rejection drugs.

Pre-certification Requirement

All transplant procedures must be pre-certified for type of transplant and be Medically Appropriate according to criteria established by the Plan.

11. **Breast Reconstruction and Breast Prostheses**: Charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complication, including lymphedema therapy, are covered.

12. **Durable Medical Equipment:** Except for the exclusions set forth below, charges for the rental of Durable Medical Equipment (up to the purchase price of the equipment) that is ordered or prescribed by a physician and is appropriate for in home use, provided that such equipment is used to improve the functions of a malformed part of the body or to prevent or slow further decline of the patient's medical condition. Charges for repair, replacement or duplicative equipment shall be paid only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a Participant's misuse shall be the responsibility of the Participant.

Definition of "Durable Medical Equipment":

The term "Durable Medical Equipment" is defined as equipment which meets the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;

- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or injured;
- It is ordered by a physician;
- The physician certifies in writing the medical necessity for the equipment;
- The physician also states the length of time the equipment will be required;
- It is related to the patient's physical disorder.

Durable Medical Equipment Items Excluded from Coverage:

Expenses for the following Durable Medical Equipment items shall not be considered "covered medical expenses":

- **Bed related items**: bed trays, over the bed tables, bed wedges, custom bedroom equipment, nonpower mattresses, pillows, posturepedic mattresses, low air mattresses (powered), alternating pressure mattresses.
- **Bath related items**: bath lifts, nonportable whirlpool, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, spas.
- **Chairs, Lifts and Standing Devices**: computerized or gyroscopic mobility systems, roll about chairs, geri chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if the patient is two-person transfer), vitrectomy chairs, auto tilt chairs and fixtures to real property (ceiling lifts, wheelchair ramps, automobile lifts customizations).
- **Air quality items**: room humidifiers, vaporizers, air purifiers, electrostatic machines.
- **Blood/injection related items**: blood pressure cuffs, centrifuges, nova pens, needle-less injectors.
- **Pumps**: back packs for portable pumps.
- **Dialysis Machines**.
- **Other equipment**: heat lamps, heating pads, cryounits, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adapters, Enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, exercise equipment, diathermy machines.

13. **Hospital Emergency Room Services**: Charges for hospital emergency room care in connection with a "Medical Emergency". For purposes of this Section 9.03(b)(18) the term "Medical Emergency" shall mean "a condition of recent onset and sufficient severity including, but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or cause serious harm".

14. **Hearing Aids** - A hearing aid benefit shall be provided for Employees and their Dependents, whose contribution rates are $3.24 per hour and above. Your schedule of benefits specifies the maximum dollar amount for each Hearing Aid benefit that will be paid by the Fund under this Section. In no event shall the Fund pay more than such maximum amount for any Employee or Dependent in any 24 month period.

(c) **Preventive Health Services**

Effective July 1, 2012, the Plan will pay 100% of the cost of all "Preventive Health Services" required by the Affordable Care Act when such services are provided by Network Healthcare Providers. Such services include well-care baby visits, preventive care physical examinations for adults, screening tests for children and adults, and immunizations for children and adults. Set forth below is an overview of the types of preventive services which are covered. If you have questions as to whether a particular service is a "Preventive Health Service" required to be provided by the Plan without cost to you under the Affordable Care Act, please call the Claims Administrator at 1-877-331-4329.

CHILD PREVENTIVE CARE (Birth to 18 years)	**ADULT PREVENTIVE CARE (19 years and older)**
Preventive physical exams including well baby	

care Age-appropriate screening tests including: - Newborn screenings - Vision screening - Hearing screening - Developmental and behavioral assessments - Oral health assessment - Screening for lead exposure - Hemoglobin or hematocrit (blood count) - Blood pressure - Height, weight and body mass index (BMI)\ - Cholesterol and lipid level screening - Screening for depression - Screening and counseling for obesity - Behavioral counseling to promote a healthy diet - Screening for sexually transmitted infections - Pelvic exam and Pap test, including screening for cervical cancer -urinalysis -tuberculin tests -blood tests including hematocrit, hemoglobin and screening for sickle hemoglobinopathy Immunizations: - Hepatitis A - Hepatitis B - Diphtheria, Tetanus, Pertussis - Varicella (chicken pox) - Influenza (flu) - Pneumococcal (pneumonia) - Human Papillomavirus (HPV) - Haemophilus Influenza type b (Hib) - Polio - Measles, Mumps, Rubella (MMR) - Meningococcal (meningitis) - Rotavirus	Preventive physical exams Age-appropriate screening tests including: - Eye chart vision screening - Hearing screening - Cholesterol and lipid level screening - Blood pressure - Height, weight and BMI - Screening for depression - Diabetes screening - Prostate cancer screening including digital rectal exam and PSAtest - Breast cancer screening, including exam and mammography - Pelvic exam and Pap test, including screening for cervical cancer - Screening for sexually transmitted infections - HIV screening - Bone density test to screen for osteoporosis - Colorectal cancer screening including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate) - Aortic aneurysm screening (men) - Screenings during pregnancy (including but not limited to, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV) - Intervention services (includes counseling and education): ° Screening and counseling for obesity ° Genetic counseling for women with a family history of breast or ovarian cancer ° Behavioral counseling to promote a healthy diet ° Primary care intervention to promote breastfeeding ° Counseling related to aspirin use for the prevention of cardiovascular disease (does not include coverage for aspirin) ° Screening and behavioral counseling related to tobacco use ° Screening and behavioral counseling related to alcohol misuse Immunizations: - Hepatitis A - Hepatitis B - Diphtheria, Tetanus, Pertussis - Varicella (chicken pox) - Influenza (flu) - Pneumococcal (pneumonia) - Human Papillomavirus (HPV) - Measles, Mumps, Rubella (MMR) - Meningococcal (meningitis) - Zoster (shingles) **WOMEN'S HEALTH CARE**

	- Women's Contraceptives, sterilization procedures, and counseling - Breastfeeding support, supplies and counseling. Benefits for breast pumps are limited to one pump per calendar year - Gastational Diabetes Screening

9.04 **Skilled Nursing Facility Care** - This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

• a favorable prognosis;

• a reasonably predictable recovery time; and

• services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member's residence.

Covered Services include:

• semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate room rate toward the charge for the private room;

• use of special care rooms;

• pathology and radiology;

• physical or speech therapy;

• oxygen and other gas therapy;

• drugs and solutions used while a patient; or

• gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care. Benefits will not be provided when:

• A Member reaches the maximum level of recovery possible and no longer requires other than routine care;

• Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;

• Care is for mental illness including drug addiction, chronic brain syndromes and alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;

• A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;

• The care rendered is for other than Skilled Convalescent Care.

9.05 **Home Health Care Services** -Home Health Care provides a program for the Member's care and treatment in the home. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network or Out-of-Network Providers.

Some special conditions apply:

• The Physician's statement and recommended program must be pre-certified.

• Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis.

Note: Covered Services available under Home Health Care do NOT reduce Outpatient benefits available under the Physical Therapy section shown in this Plan.

• A Member must be essentially confined at home.

Covered Services:

• Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.

• Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.0

• Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.

• Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.

• Nutritional guidance when Medically Necessary.

• Administration or infusion of prescribed drugs.

• Oxygen and its administration.

Covered Services for Home Health Care do not include:

• Food, housing, homemaker services, sitters, home-delivered meals.

• Home Health Care services which are not Medically Necessary or of a non-skilled level of care.

• Services and/or supplies which are not included in the Home Health Care plan as described.

• Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's spouse/domestic partner.

• Any services for any period during which the Member is not under the continuing care of a Physician.

• Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member.

• Any services or supplies not specifically listed as Covered Services.

• Routine care and/or examination of a newborn child.

• Dietician services.

• Maintenance therapy.

• Dialysis treatment.

• Purchase or rental of dialysis equipment.

9.06 **Medical Expenses Not Covered**. No payment will be made for medical expenses incurred for which benefits are not payable under the General Exclusions and Limitations set forth at Section 23 hereof or for private Hospital rooms unless such rooms are determined to be Medically Necessary or the Hospital only offers private rooms.

9.07 **Pre-Certification**

(a) **Definition of Pre-Certification.** Pre-Certification is the process used to obtain authorization for a specific medical procedure before it is done, or to obtain authorization for admission to a hospital for medical treatment before such admission takes place.

(b) **When Pre-Certification is Required.** Pre-Certification is required for any in-patient admission to a Hospital. **In addition**, Pre-Certification is required for certain out-patient medical services. A description of the out-patient services which require Pre-Certification under the Plan is set forth in the Appendix to the Summary Plan Description entitled "**Out-Patient Services Requiring Pre-Certification**".

(c) **Emergency Medical Treatment.** If a Participant is admitted to a hospital on an emergency basis, either the Participant or his or her authorized representative or physician must notify the Claims Administrator within two (2) business days after the admission, or as soon as possible within a reasonable period of time, by calling the telephone number on his or her Medical Plan ID Card.

(d) **Procedure for Obtaining Pre-Certification.**

1. If the Healthcare Provider is a Network Healthcare Provider in the states of California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, New Hampshire, Nevada, Ohio, Virginia and Wisconsin.

The Healthcare Provider is responsible for obtaining Pre-Certification.

2. If services are provided by a Network Provider in any other state or by an Out-of-Network Healthcare Provider.

The Participant, or his or her authorized representative, are responsible to confirm that Pre-Certification has been obtained.

(e) **Standard to be Applied.** The Claims Administrator will not provide Pre-Certification for any medical service that is either not a medical service covered by the Plan or is not deemed to be medically necessary.

(f) **Consequence.** If Pre-Certification is not obtained before the hospital admission (unless emergency) or the out-patient medical service is provided, the Participant will be financially responsible for the cost of the hospitalization or medical service in question.

(g) **Time Frames for Determination of Pre-Certification.** A request for Pre-Certification is considered "Urgent" when, in the opinion of the treating Healthcare Provider the failure to receive the requested care or treatment would seriously jeopardize the life or health of the Participant or his or her Covered Family Member, or the ability of the Participant or his or her Covered Family Member to regain maximum function, or subject the Participant or his or her Covered Family Member to severe pain that cannot be adequately managed without such care or treatment.

When the request for Pre-Certification is termed as "Urgent" the Claims Administrator shall respond within 72 hours from the receipt of the request. When the request for Pre-Certification is termed as non-urgent, the Claims Administrator will respond within 15 calendar days from the receipt of the request.

(h) **Appeal from Denial of Pre-Certification.** In the event the Claims Administrator denies Pre-Certification for any hospitalization or out-patient service, the Participant shall have the right to appeal such a denial pursuant to the appeal procedures set forth at Section 18 of this Plan Document.

SECTION 10. MATERNITY

10.01 **Payment of Medical Benefits for Maternity.** For purpose of computing medical benefits, maternity shall be treated by this Plan as any other illness for female Employees or wives of employees.

10.02 **Covered Children.** No benefits shall be paid by the Fund for any medical treatment arising out of maternity care for Covered Children of Employees.

SECTION 11. VISION CARE BENEFITS

11.01 **Payment of Vision Care Benefits.** The Fund shall pay a vision care benefit to an Employee or Covered Family Member for an eye examination and toward the purchase of frames and single vision, bifocal or higher vision lenses. The amount of vision care benefits shall be the same for all Employees and Covered Family Members regardless of benefit classification and is specified in your Schedule of Benefits.

11.02 **Maximum Benefit.** Your Schedule of Benefits specifies the maximum dollar amount for each vision care benefit that will be paid by the Fund under this Section. In no event shall the Fund pay more than such maximum amount for any Employee or Covered Family Member in any 24 month period.

11.03 **Contact Lenses.** Benefits for examination leading to the providing of contact lenses and for the actual providing of the contact lenses shall be paid at the same rate as an examination and providing of single vision lenses.

11.04 **Restrictions on Payment of Vision Benefits.** Vision care benefits shall not be payable for:

(a) Procedures or supplies furnished on account of visual defect which arises out of or in the course of employment;

(b) Declared or undeclared war, or any act thereof, or military or naval service for any country;

(c) Any medical or surgical treatment of the eye;

(d) Sunglasses plain or prescription, or safety lenses or goggles;

(e) Othoptics, vision training or aniseikonia.

SECTION 12. DENTAL EXPENSE BENEFITS

12.01 Subject to the maximum and deductible amounts specified in this Section, the Fund shall pay benefits for certain dental procedures incurred by Employees and their Covered Family Members.

12.02 **Payment of Deductible**. For purposes of the dental expenses covered by this Section 12, each person covered by this Plan, whether Employee or Covered Family Member, shall pay the deductible of such expenses per calendar year.

12.03 **Maximum Amount Paid by Plan.** With the exception of prosthetics (false teeth and adjustment and the repair thereto) the Fund shall pay 75% of the balance of any covered dental expense up to the maximum dental benefit provided under this Plan. The maximum dental benefit per Employee and Covered Family Member is the same regardless of benefit classification and is specified in your Schedule of Benefits.

12.04 **Dental Expenses Covered by the Plan.** With the exception of prosthetics and teeth cleaning, the dental expenses which are covered by this Plan include the charges of a duly licensed dentist for professional services and supplies rendered in connection with:

1. Diagnostic services/office visits, consultations, diagnostic procedures;

2. Oral surgery - extractions, or other dental surgical procedures including pre and post-operative care;

3. Restorative dentistry - amalgam, synthetic porcelain and plastic restorations; or, in the event it is determined by the dentist that restoration is not practicable by means of a filling material, gold restoration by means of crowns and jackets;

4. Endodontics - Pulp therapy and root canal filling;

5. Periodontics - All necessary procedures for the treatment of diseases of the gums and bones supporting the teeth;

6. Preventative – Sealant coverage for covered children only up to age 15**.**

12.05 **Prosthetics and Teeth Cleaning.**

A. The Fund shall pay 45% of the charges incurred in connection with prosthetics up to the maximum dental benefit allowable. An Employee or Covered Family Member shall be entitled to benefits for prosthetics when such charges are incurred:

1. After a period of twelve (12) consecutive months during which the Employee has been continually eligible for benefits;

2. With respect to no more than one prosthetic appliance in any period of five (5) consecutive years.

B. Teeth Cleaning - Dental benefits for teeth cleaning or prophylaxis (removal of tartar stains from

exposed surfaces of the teeth by scaling and polishing) shall be paid in the same manner as other covered dental benefits. However, covered dental expenses with respect to prophylaxis shall be limited to charges incurred for one treatment in any period of six (6) consecutive months.

12.06 **Exclusions From Covered Dental Expenses.** Covered dental expense benefits under this Plan do not include and no benefits shall be payable for or on account of any of the following:

1. Any charges whatsoever that were incurred prior to the effective date of eligibility for benefits under this Plan;

2. Charges incurred in connection with the treatment of a congenital malformation, except that this exclusion shall not apply to such charges when they are incurred following a period of thirty-six (36) consecutive months during which the Employee has been continuously eligible for benefits under this Plan;

3. Charges incurred in connection with any treatment to the teeth or gums for tumors;

4. Charges incurred for services purely cosmetic in nature;

5. Charges incurred for services or supplies that are unreasonably priced or not reasonably necessary in light of the dental procedure being treated. For the purpose of determining whether a particular charge comes within this exclusion, the Fund shall take into consideration the fees and prices generally charged and the services and supplies generally furnished in the area concerned for cases comparable to the case being treated. In no event shall payment for fees and charges equivalent to those made by the California Medical Assistance (commonly referred to as Medi-Cal), in the area concerned, be considered unreasonable. It is the intent of this exclusion that the benefits hereunder shall not cover charges for services or supplies that a reasonable person would consider to be priced unreasonably high or to be of a luxury nature;

6. Charges incurred in connection with any dental injury (a) which arises out of or in the course of any occupation or employment for wage or profit; or (b) for which the Employee or Covered Family Member is entitled to benefits under any worker's compensation or occupational disease law.

7. Services furnished by a hospital or facility operated by any national, state, county or provincial government, or political subdivision thereof, or by any authorized agency, unless a charge is made to the individual imposing an unconditional requirement of payment without regard to the existence of benefits. For example, if an Employee or Covered Family Member is entitled to services at a facility operated by any agency of the federal government and such services are furnished at the expense of the government or agency involved, the Fund is not obligated to pay for such services.

8. Charges incurred in connection with orthodontic services.

SECTION 13. PRESCRIPTION DRUG BENEFITS

13.01 **Payment of Prescription Drug Benefits**. The Fund shall pay prescription drug benefits to a Participant in accordance with the amounts and terms set forth in the applicable Schedule of Benefits, provided that the prescription drugs are obtained pursuant to a prescription issued by a Physician or other Health Care Provider licensed to issue prescriptions. Payment shall be made at 75% of the charge for such prescription drug up to the maximum payment set forth in the applicable Schedule of Benefits.

13.02 **Definition of Prescription Drug**. For purposes of this Section 13, the term "prescription drug" shall mean a drug available to the public only upon prescription written by a Physician, or other Health Care Provider licensed to issue a prescription.

13.03 **Definition of Prescription**. For purposes of this Section 13, the term "Prescription" shall mean a written direction or order for dispensing and administering drugs signed by a Physician, or other Health Care Provider licensed by law to prescribe such a drug.

13.04 **Birth Control**. Birth Control benefits shall be payable only to female Employees or wives of male Employees.

13.05 **Exclusions**.

Prescription drug benefits shall not be payable in connection with the following:

- Any medications which have been withdrawn from the market by the Food and Drug

Administration,
- Any medications which have not been approved for use by the Food and Drug Administration,
- Any medication imported into the United States without the approval of the U.S. Food and Drug Administration,
- Any drug which can legally be bought without a prescription,
- Therapeutic devices or appliances or other non-medical substances, regardless of their intended use,
- Administration or injection of any drug,
- Administration of allergy shots,
- Drugs used to treat obesity or assist weight reduction; anorexiants,
- Immunization agents, biological sera, blood and blood plasma,
- Any drug for cosmetic purposes,
- Rogaine and like drugs,
- Retin-A for a Participant over age 30,
- Any prescription refilled in excess of the number of refills specified in the prescription or any prescription or refill dispensed more than one year after the original prescription,
- Any drug which is dispensed to, administered to, or consumed by a participant in whole or in part, while a patient in a licensed hospital or other institution covered by this plan,
- Any drug which is consumed or administered at the place where it is dispensed,
- Prescriptions filled prior to the effective date or after the termination date of the participant's coverage, regardless of when the prescription was issued,
- Drugs labeled "Caution - Limited by Federal law to Investigational Use"; drugs which are experimental or investigational in nature, or which are in connection with experimental or investigative services or supplies, medications or supplies rendered to a participant.
- Prescription drugs utilized in connection with in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or like procedures.

SECTION 14. EXTENSION OF BENEFITS DURING PERIOD OF DISABILITY

14.01 **Extension of Benefits for First Two Months of Disability Period.** If an Employee is disabled and no contributions are being made on his or her behalf, benefits under this Plan for such Employee and his or her Covered Family Members shall be continued for a period of two months from the date of the last contribution period for such Employee.

14.02 **Continuation of Benefits After Two Months of Disability.** If an Employee wishes to continue medical, vision and dental care benefits following said two month period, application must be made for Continuation of Coverage as described in Section 15 hereof. If an Employee does not choose to elect Continuation of Coverage, all benefits for such Employee and his or her Covered Family Member will cease at the end of two months following the end date of the last contribution period. However, the Fund shall continue to pay for covered expenses up to the maximum amount of benefits payable for the disability that prevented the Employee's return to work for no more than 26 weeks following the first date of disability.

SECTION 15. CONTINUATION OF COVERAGE FOR MEDICAL, VISION, DENTAL AND PRESCRIPTION DRUG BENEFITS

15.01 **Eligibility for Continuation of Coverage.**

(a) No Employee or Covered Family Member thereof shall be eligible for Continuation of Coverage unless the Employee has submitted an enrollment card to the Fund Office which includes his or her full name and address as well as the full name and address of his or her Covered Family Members.

(b) An Employee and his or her Covered Family Members are eligible, at their own expense, for continuation of medical, vision, dental and prescription drug benefits in the event of the termination of employment of such Employee. The term "Termination of Employment" includes termination of employment, voluntary or involuntary, for any reason which results in an Employee's loss of eligibility for benefits. This would include unpaid leaves of absence not covered by the Federal Family and Medical Leave Act and periods of disability not covered by the Federal Family and Medical Leave Act extending more than two months from the date of an Employee's last contribution period.

(c) A spouse is eligible, at his or her own expense, for continuation of medical, vision, dental and prescription drug benefits in the event of divorce or separation from a covered Employee.

(d) A Covered Family Member is eligible, at his or her own expense, for continuation of medical, vision, dental and prescription drug benefits in the event of the death of a spouse or parent who is a covered Employee.

(e) A Covered Child is eligible at his or her own expense, for continuation of medical, vision, dental and prescription drug benefits at such time as he or she loses status under the definition of "Covered Family Member".

(f) In the event an Employee's hourly work schedule is reduced in hours so as to result in a drop to a lower Benefit Classification Level under this Plan (for example, an Employee dropping from Level IV to Level III as a result of a reduction of his or her weekly work schedule from 35 to 25 hours per week), such Employee and his or her Covered Family Members, at their own expense, are eligible to maintain their medical, vision, dental and prescription drug benefits at the Benefit Classification Level they held prior to the decrease in the Employee's weekly work schedule.

(g) No Employee or Covered Family Member thereof shall be eligible for Continuation of Coverage in the event he, she or they are covered by another group medical plan.

15.02 **Qualifying Event.** The term "Qualifying Event" shall mean any of the following events which result in a loss of eligibility for medical, vision and dental care benefits, or a reduction in such benefits:

(1) Termination of Employment;

(2) Death of the Employee;

(3) Divorce or Legal Separation;

(4) Loss of Covered Child Status;

(5) Reduction in weekly work schedule resulting in a drop to lower Benefit Classification Level.

(6) Exhaustion of leave under the Federal Family and Medical Leave Act without a return to employment.

(7) An Employee COBRA Participant becomes eligible for Medicare benefits during a period of time when his or her Covered Family Member COBRA Participants are not Medicare eligible.

15.03 **Notice of Right to Continuation of Coverage.**

(a) The Fund Office shall send notice to all Employees and Covered Family Members for whom they have received enrollment cards, notifying such Employees and Covered Family Members of their rights to Continuation of Coverage for medical, vision, dental and prescription drug benefits.

(b) Within 30 days of receipt of any enrollment card submitted by an Employee, the Fund Office will send a General Notice in conformity with applicable Federal law to such Employee and his or her Covered Family Members informing them of their rights to continuation of coverage for medical, vision, dental and prescription drug benefits.

(c) All Employers must notify the Fund Office within 30 days of the date of an Employee's death, termination of employment or reduction in weekly work schedule which results in such Employee being dropped to a lower Benefit Classification Level. In addition, the affected Employee may also give such notice to the Fund Office.

(d) Each covered Employee or Covered Family Member is responsible for notifying the Fund Office in the event of a divorce or legal separation of the Employee from his or her spouse, or a Covered Child ceasing to be a Covered Child under the requirements of this Plan. Such Employee or Covered Family Member must give notice to the Fund Office of such Qualifying Event within 60 days after the date of the Qualifying Event. In the event the Employee or Covered Family Member does not give notice of such Qualifying Event to the Fund Office within 60 days after its occurrence, such Employee and his or her Covered Family Members shall lose eligibility for Continuation of Coverage.

(e) Within 14 days of the date on which the Fund Office receives notice of a Qualifying Event from either an Employer, Employee or Covered Family Member, the Fund Office shall notify such Employee and his or her Covered Family Members of their rights to continuation of coverage for

medical, vision, dental and prescription drug benefits and shall submit appropriate claim forms to the said Employee and his or her Covered Family Members for use in applying for Continuation of Coverage. Notification to the spouse of the Employee shall be considered notice to all other Covered Family Members residing with such spouse at the time such notification is made. Such notification shall be in conformity with applicable Federal law.

(f) If the Fund determines that an Employee or Covered Family Member is not entitled to Continuation of Coverage the Fund office shall so notify such Employee or Covered Family Member within 14 days of the date the Fund office receives notice of a Qualifying Event. Such notice shall be in conformity with Federal law and shall explain why the Employee or Covered Family Member is not entitled to Continuation of Coverage.

15.04 **Election of Continuation of Coverage.**

(a) If an Employee or Covered Family Member elects to receive Continuation of Coverage, he or she must so notify the Fund Office, on forms prepared by the Fund Office, within 60 days after the later of (i) the date that such Employee or Covered Family Member would lose coverage for medical, vision, dental and prescription drug benefits or have such coverage reduced by reason of a Qualifying Event, or (ii) the date such Employee or Covered Family Member is sent notice by the Fund Office of his or her right to elect Continuation of Coverage. If such Employee or Covered Family Member does not submit such notice to the Fund Office on forms prepared by the Fund Office, within such 60 day period, the Employee or Covered Family Member will not be eligible for Continuation of Coverage.

EXAMPLE 1

An Employee is terminated from employment on October 1 and is sent notice of his or her right to elect Continuation of Coverage from the Fund Office on October 15th. The Employee, or his or her Covered Family Member , must send a notice to the Fund Office, on forms prepared by the Fund Office, electing to continue coverage no later than the 60th day following October 15th.

EXAMPLE 2

An Employee is terminated from Employment on October 1 by reason of disability and is sent notice of his or her right to elect Continuation of Coverage from the Fund Office on October 15. Under the provision for Extension of Benefits During A Period of Disability spelled out previously, the Employee and his or her Covered Family Members retain their eligibility for benefits for a period of two months from the date of the Employee's last contribution period. Accordingly, the Employee or Covered Family Member in this situation would be required to send notice of his or her election to continue coverage no later than the 60th day following the period ending two months after the date of his or her last contribution period.

(b) In making such election to continue coverage, the Employee, spouse of such Employee or child of such Employee who has lost Covered Family Member status, may separately elect to continue coverage for medical care benefits only or for medical, vision, dental and prescription drug benefits. The notice sent by the Fund Office to the Employee and his or her Covered Family Members informing them of their rights to Continuation of Coverage shall include a description of the cost to the Employee and his or her Covered Family Members if they elect coverage for medical care only or they elect coverage for medical, vision, dental and prescription drug benefits. If an Employee makes an election to provide any Covered Family Member with Continuation of Coverage, that election shall be binding on the Covered Family Member in question. An election on behalf of a minor child may be made by the child's parent or legal guardian. An election on behalf of an Employee or Covered Family Member who is incapacitated may be made by the legal representative of such Employee or Covered Family Member or by the spouse of such Employee or Covered Family Member.

15.05 **Duration of Continuation of Coverage.**

(a) Termination of Employment or Reduction in Weekly Work Schedule. In the event an Employee or Covered Family Member applies for continuation of coverage by reason of a termination of employment or reduction in weekly work schedule, the maximum period of Continuation of Coverage shall be 18 months from the date of the Qualifying Event.

(b) Death, Divorce, Legal Separation or Loss of Covered Child Status. In the event an Employee or Covered Family Member applies for Continuation of Coverage as a result of the Employee's death, divorce, legal separation or the loss of Coverd Family Member status of a Covered Child, the maximum period of Continuation of Coverage shall be 36 months from the date of the Qualifying

Event.

(c) If a second Qualifying Event (for example, a death or divorce) takes place within the 18 month maximum coverage period following the termination of employment or reduction of weekly work schedule the original 18 month period of Continuation of Coverage may be expanded to 36 months following the date of the original Qualifying Event (the termination of employment or reduction in weekly work schedule) for those individuals who were Covered Family Members as of the time of the first Qualifying Event and remain covered by the Fund at the time of the second Qualifying Event. In no event shall Continuation of Coverage exceed 36 months in total.

(d) If Continuation of Coverage is provided for 18 months due to termination of employment or reduction in hours and the Participant is determined by the Social Security Administration within 18 months of the Qualifying Event to have been disabled as of the date the Participant would have lost coverage under the Plan in the absence of self-payments, the Continuation of Coverage may be extended from 18 to 29 months or until the Participant recovers from the disability, if sooner.

(e) Notwithstanding an election to continue coverage for the 18 month or 36 month periods described above, an Employee's or the Covered Family Member's right to Continuation of Coverage shall terminate on such date as:

(1) The Fund ceases to provide any medical, vision, dental or prescription drug benefits to any active Employees; or

(2) An Employee or Covered Family Member fails to make timely payment of the premium required of such Employee or Covered Family Member;

(3) An individual receiving Continuation of Coverage becomes eligible for Medicare; or

(4) The Employee or Covered Family Member becomes covered under another group health care plan because of a new job or marriage.

In the event of such early termination of Continuation of Coverage the Fund office shall send a notice to the affected Employee or Covered Family Member as soon as practicable after the determination to terminate Continuation of Coverage, informing the Employee or Covered Family Member of:

- The reason for the termination;
- The effective date of the termination; and
- Any right to elect alternative coverage.

15.06 **Cost to Employee or Covered Family Memberfor Continuation of Coverage.**

(1) The Trustees, in conjunction with the Fund actuary, shall calculate the cost of providing coverage for an Employee and/or his or her Covered Family Members for medical care benefits only and for medical, vision, dental and prescription drug benefits together. The amount of the premium payable by the Employee and/or his or her Covered Family Members shall be 102% of such cost calculated by the Trustees and Fund actuary. The Employee and his or her Covered Family Members shall be notified of the amount of the applicable premium in the notice sent to the Employee and his or her Covered Family Members by the Fund Office following the happening of the Qualifying Event.

(2) Applicable premiums for Continuation of Coverage shall be established by the Trustees for each 12 months period commencing October 1. In the event there is an increase in the cost of the applicable premium which is put into effect by the Trustees on an October 1 which falls within any Continuation of Coverage period, the Trustees shall so notify the Employee and/or his or her Covered Family Members by October 15th. In such event, the Employee and/or his or her Covered Family Members will be required to pay the increased applicable premium in order to continue eligibility for Continuation of Coverage.

(3) In order to maintain eligibility for Continuation of Coverage an Employee and/or his or her Covered Family Member must make premium payments no later than 30 days following the month for which they are eligible for such coverage. For example, an Employee or his or her Covered Family Members must submit their premium payment no later than the end of February in order to insure Continuation of Coverage for the month of January.

(4) If an election to obtain Continuation of Coverage is made by an Employee or Covered Family Member after the date of the Qualifying Event, the Fund shall provide Continuation of Coverage for the period following the Qualifying Event and preceding the election date so long as the first

premium payment is made within 45 days of the date the Employee and/or Covered Family Member submits a notice of election to the Fund Office on forms prescribed by the Trustees.

(5) In the event an Employee or Covered Family Member fails to make timely payments of premiums as specified herein, they shall no longer be eligible for Continuation of Coverage.

(6) In the event an Employee experiences a Qualifying Event as the result of an involuntary termination of employment at any time from September 1, 2008, through May 31, 2010, and is otherwise eligible for Continuation of Coverage under the Plan, such Employee and/or his/her Covered Family Member, may be eligible for a 65% premium reduction for up to 9 months, starting no earlier than February 17, 2009. Questions regarding eligibility for such reduced premium, what constitutes "involuntary termination" from employment, application for such reduced premium and the length of time such reduced premium shall be in effect will be governed by the terms of the American Recovery and Reinvestment Act (ARRA), and regulations promulgated by the United States Department of Labor pursuant thereto. The Plan Office shall send Notices to all Employees experiencing qualifying events between September 1, 2008 and May 31, 2010, explaining their rights to reduced premium coverage under ARRA. For additional information regarding your rights to premium reduction under ARRA, you may write or call the Fund Office.

SECTION 16. TIME LIMIT FOR FILING CLAIMS

~~16.01 All claims for benefits provided by this Plan must be submitted within one year from the date the claim is "incurred". Any claim received by the Plan Office or Claims Administrator more than one (1) year after the claim is incurred will not be honored and will not be paid.~~

16.01 - Except as set forth in Section 16.02 hereof, all claims for benefits provided by this Plan must be submitted within one (1) year from the day the claim is "incurred". Any claim received by the Plan Office or Claims Administrator more than one (1) year after the claim is incurred will not be honored and will not be paid.

16.02 - All claims for Death Benefits, Non-Occupational Accidental Death and Dismemberment, or Survivor Death Benefits under Sections 5, 6 and 7 hereof, must be submitted within three (3) years from the date of the death or dismemberment question. Any such claim received by the Plan Office more than three (3) years after the date of death or dismemberment will not be honored and will not be paid.

SECTION 17. CLAIMS REVIEW AND APPEAL PROCEDURES - CLAIMS FOR MEDICAL BENEFITS

17.01. **Claims Administrator**. Effective July 1, 2012 all claims for medical benefits and appeals from denials of such claims shall be handled exclusively by the Claims Administrator (Anthem). It shall be the responsibility of the Participant to give proper notice of any other medical coverage he or she may have when filing a claim with the Claims Administrator (Anthem) for medical benefits. **All of the time limitations set forth below begin running from the time of receipt of the claim by the Claim Administrator (Anthem).**

17.02. **Claims Review Procedures**. For purposes of these Claims Review Procedures, the term "claim for benefits" means a request for medical benefits under the Plan. The term includes both pre-service and post-service claims.

- Pre-service claim is a claim for benefits under the Plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the Plan for which you have received the service.

If your claim is denied:

- you will be provided with a written notice of the denial; and
- you are entitled to a full and fair review of the denial.

17.03. **Notice of Adverse Benefit Determination.** If your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

17.04. **Urgent Care**. A claim shall be considered to involve "urgent care" if it is a claim for medical care with respect to which the application of the time period for making non-urgent care determinations could:

(a) Seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(b) In the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

For claims involving urgent care:

- The Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- The Claims Administrator may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

17.05. **Appeals**.

(a) **General Information Regarding Appeals.** You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which shall be an independent or external review.

(b) **Appeal of Urgent Care Claims**. For pre-service claims involving urgent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claims Administrator at the telephone number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and

- any reasons why the appeal should be processed on a more expedited basis.

(c) **Appeals of Non-Urgent Care Claims**. All other requests for appeals should be submitted in writing by the Participant or the Participant's authorized representative. You or your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, GA30348-5568

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
-is a statement of the Plan's policy or guidance about the treatment or benefit relative to your diagnosis.

The Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale.

(d) **How Your Appeal Will Be Decided.** When the Claims Administrator considers your appeal, the Claims Administrator will not rely upon the initial benefit determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

(e) **Notification of the Outcome of the Appeal.**

i. **If you appeal a claim involving urgent care**, the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

ii. **If you appeal any other pre-service claim,** the Claims Administrator will notify you of the outcome of the appeal within 30 days after
receipt of your request for appeal.

iii. **If you appeal a post-service claim,** the Claims Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

(f) **Appeal Denial**. If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator (Anthem) will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

(g) **External Review**.

i. If the outcome of the mandatory first level appeal is adverse to you, you are eligible for an independent External Review pursuant to federal law. The term "external review" refers to your right to have the decision reviewed by independent health care professionals who have no association with the Claims Administrator. By voluntarily requesting an External Review you are agreeing to have your Protected Health Information reviewed by the independent health care professionals conducting such review.

ii. A request for External Review must be submitted by you or your representative to the Claims Administrator (Anthem) within four (4) months of the notice of your final internal adverse determination. A request for an External Review must be in writing unless the Claims Administrator (Anthem) determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for the internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

iii. For urgent care claims, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's (Anthem's) decision, can be sent between the Claims Administrator (Anthem) and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at [the number shown on your identification card] and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

iv. For non-urgent care claims, all other requests for External Review should be submitted in writing unless the Claims Administrator (Anthem) determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105668 Atlanta, GA 30348-5568

v. **Request for External Review is Voluntary**. In order to fulfill your appeal procedure obligations it is not necessary that you request External Review. Such a request is purely voluntary on your part. Your decision to seek External Review will not affect your rights to any other benefits under the Plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

(h) **Requirement to file an Appeal before filing a lawsuit**. You must exhaust the Plan's Claims Review Procedure, not including any voluntary External Review, before filing a lawsuit or taking other legal action of any kind against the Plan. If your appeal results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA. No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within the time provided by the applicable Statute of Limitations. If the Claims Administrator decides an appeal is untimely, the Claims Administrator's latest decision on the merits of the underlying claim or benefit request is the final decision date."

18. CLAIMS REVIEW AND APPEAL PROCEDURES – CLAIMS FOR ALL BENEFITS PROVIDED BY THE PLAN OTHER THAN MEDICAL BENEFITS

18.01. **Time Table for Determining Claims.** All of the time limitations set forth below begin running from the time of receipt of the claim by the Plan Office.

As used below, the word "process" refers to the time within which the Plan office shall determine whether a particular claim is payable.

18.02. **Claims**

To process a complete claim .....72 hours

To request additional information for an incomplete claim .....24 hours

Claimant's response time if additional information requested .....48 hours

To process a claim if complete information received ..... 48 hours

18.03. **Denial of Claims.** If the claim is denied, the Plan Office will provide the affected Employee, Covered Family Member or their representative with the following information:

1. The specific reason for the determination;

2. Reference to the specific claims provisions on which the determination is based;

3. A description of any additional material or information necessary for you to provide to the Plan and an explanation of why the information is necessary (if applicable);

4. A description of the Plan's Claim Review Procedures and Time Limits to appeal a denial, including a statement of your right to bring a civil action under Section 502 (a) of ERISA following an adverse benefit determination on review; and

5. A statement of any specific internal rule, guideline, protocol or other matter that was relied upon in making the benefit denial.

18.04. **Request For Review of Denial of Claims**. Within one hundred and eighty (180) days after you receive written notice that your claim has been denied, you or your representative may make a written request for a review. Your request for review must be received by the Plan within one hundred and eighty (180) days after you receive notice that your claim has been denied. Your written request for review should contain your Social Security Number and a statement of the reasons why you believe the denial of your claim was in error.

18.05. **Procedure To Be Followed In Reviewing Denial of Claims**. Requests for review of denied claims will be considered and decided by a Committee designated by the Board of Trustees. Such Committee shall not include any person who participated in the initial determination to deny the claim or who is a subordinate of any individual who participated in the initial determination.

18.06. **Time Table For Decision On Review Of A Denied Claim**. Written or electronic notice of the Committee's determination on review of a claim must be transmitted to the claimant within sixty (60) days after receipt of the written request for review.

18.07. **Contents Of Determination On Appeal**. If a request for review is denied, the notice of the Committee's determination must set forth:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific claims provision on which the determination is based;

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

4. A statement of any specific internal rule, guideline, protocol or other similar criteria that was relied upon in making the adverse determination;

5. A statement of the claimant's right to bring a civil action under Section 502 (a) of ERISA;

6. The following statement:

"You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State Insurance Regulatory Agency."

SECTION 19. AUTHORITY OF TRUSTEES.

The Trustees shall have full authority and power, in their absolute discretion to determine the following matters and all questions, policies and procedures related thereto:

(a) the construction of the provision of all Plan documents, including, but not limited to, this ITPEU Health and Welfare Plan, the Agreement and Declaration of Trust and all resolutions and amendments adopted pursuant to those documents, including all terms used within such documents;

(b) the nature and amount of all benefits to be provided under the Plan;

(c) eligibility to participate in the Plan;

(d) eligibility to receive benefits from the Plan.

All decisions of the Trustees, or such Committees of Trustees or representatives of the Trustees as shall be designated by the full Board of Trustees, on any question regarding the construction of any Plan document, or any question regarding the nature and amount of benefits, eligibility to participate in the Plan and eligibility to receive benefits shall be final and binding on all participants, beneficiaries and any other interested parties.

SECTION 20. COORDINATION OF BENEFITS

20.01 **General Rule**. If an individual is entitled to benefits or services for which benefits are allowable under the ITPEU Health and Welfare Plan, and is also covered under any other Plan, as defined in Section 20.02 hereof, the benefit provided by the ITPEU Health and Welfare Plan will be coordinated so that the combination of such benefit payments does not exceed the maximum benefit payable by the ITPEU Health and Welfare Plan for the claim in question.

20.02 **Definition of "Plan".** As used in this Section 20, the term "Plan" shall mean a plan listed below which covers medical, dental, vision or health benefits and services:

(a) Other plans which cover people as a group;

(b) A self-insured or non-insured plan or other plan which is arranged through an Employer, Trustee or Union;

(c) A pre-payment plan which provides medical, vision, dental or health service;

(d) Government plans which are in effect on the date the ITPEU Health and Welfare Plan becomes effective;

(e) Group auto insurance;

(f) Single or family subscribed plan issued under a group, blanket or franchise type plan.

20.03 **Application of Coordination of Benefits**:

1. If two or more plans cover a husband and wife, benefits shall be paid in this order:

(a) Plan of spouse for whom the claim is incurred;

(b) Plan of the other spouse.

2. If two or more plans cover a Covered Child, benefits shall be paid in this order:

(a) Plan of the parent with earlier birth date in a calendar year;

(b) Plan of the parent with the later birth date in a calendar year.

3. If two or more plans cover a Covered Child of divorced or separated parents, benefits shall be paid in this order:

(a) The plan of the parent who is obligated to pay medical benefits for the Covered Child under a Qualified Medical Support Order;

(b) The plan of the parent with whom the the Covered Child primarly resides;

(c) The plan of the spouse of the parent with whom the Covered Child primarily resides;

(d) The plan of the parent with whom the Covered Child does not reside.

20.04 **Exchange of Information**. The Fund may, with the consent of the Employee or spouse of an Employee when the claim is for a spouse, or the parent or guardian when the claim is for a minor child, release or obtain any data which is needed to implement this provision. Any person who claims benefits under the ITPEU Health & Welfare Fund must, upon request, provide all information the Administrator believes is needed to coordinate benefits. All information believed necessary to coordinate benefits may be exchanged with other companies, organizations or persons.

20.05 **Facility of Payment**. When payments should have been paid under the ITPEU Health & Welfare Plan but were already paid under some other Plan, the Fund shall have the right to make payment to such other Plan of the amount which would satisfy the intent of the provision. Such payment will be considered benefits paid under the ITPEU Health & Welfare Plan and to the extent of those amounts, will discharge the Fund from liability.

20.06 **Right of Recovery**. If payments made under the ITPEU Health & Welfare Plan are in excess of the amount necessary to satisfy the intent of this provision, the Fund shall have the right to recover such excess payments from one or more of the following:

(a) Any person to whom, or for whom, the benefits were paid.

(b) And/or the other companies or organizations liable for the benefit payments.

SECTION 21. MULTIPLE EMPLOYMENT

21.01 **Employment With More Than One Employer**.

If, at the time of a claim for benefits under this Plan, an Employee has attained benefit eligibility due to employment under more than one collective bargaining agreement, such benefits shall be paid by first exhausting the benefits available under the employment in which the Employee has attained the highest Benefit Classification and then applying the benefits available as a result of employment under any other collective bargaining agreement.

In the event such Employee’s Benefit Classifications under more than one collective bargaining agreement are identical, such benefits will be paid by first exhausting the benefits available under the employment in which the Employee has worked the longest period of time, and then applying the benefits available as a result of employment under any other collective bargaining agreement.

In no event, shall the combination of such benefit payments exceed the maximum combined benefit payable under the Plan for the claim in question.

21.02 **Benefit Payments When Husband and Wife are Both Employees**.

(a) In the event both husband and wife are Employees, all benefits payable to such husband and wife shall be paid under this Plan by first exhausting the benefits available to such husband or wife as an Employee, and then applying the benefits available as a result of such person’s status as a

Covered Family Member of their spouse.

In no event, shall the combination of such benefit payments exceed the maximum combined benefit payable under the Plan for the claim in question.

(b) Benefits for Covered Children of such a husband and wife shall be paid by first exhausting the benefits available by virtue of the employment of whichever spouse has been employed longest, or, if employment time is equal, by virtue of the earliest birth date in the calendar year, and then applying the benefits available as a result of the employment of the other spouse. In no event, shall the combination of such benefit payments exceed the maximum combined benefit payable under the Plan for the claim in question.

21.03 **Benefit Payment When a Covered Child and Parent are Employees**.

In the event a Covered Child and one or both parents are Employees, all benefits payable to such Covered Child and any Employee parents of such Covered Child under this Plan, shall be paid by first exhausting the benefits available to such Covered Child as an Employee and then applying the benefits available as a result of his or her status as a Covered Family Member in accordance with the provisions of Section 20.02 (b) hereof.

SECTION 22. SUBROGATION

22.01 **General Rule**. If a Participant or Covered Family Member receives any benefits arising out of an injury or illness for which the Participant or Covered Family Member (or the Participant's or Covered Family Member's Guardian or Estate) has, may have, or asserts any claim or right to recovery against a third party or parties, any payment or payments under this Plan for such benefits shall be made on the condition and with the understanding that this Plan will be reimbursed. Such reimbursement will be made by the Participant or Covered Family Member (or the Participant's or Covered Family Member's Guardian or Estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the Participant or Covered Family Member (or the Participant's or Covered Family Member's Guardian or Estate) from: (1) any policy or contract from any insurance company or carrier (including the Participant's or Covered Family Member's insurer) and/or (2) any third party, plan or funds as a result of a judgment or settlement. The Participant or Covered Family Member on behalf of him or herself (or his or her Guardian or Estate) acknowledges and agrees that this Plan will be reimbursed in full before any amounts (including attorney's fees incurred by the Participant or Covered Family Member or his or her Guardian or Estate) are deducted from the policy proceeds**,** judgment or settlement, regardless of the manner in which the recovery is structured or worded.

22.02 **Amount of Subrogation**. This Plan will be subrogated to all claims, demands, actions and right of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including the Participant's or Covered Family Member's insurer) to the fullest extent permitted by law in the appropriate jurisdiction. The amount of such subrogation will equal the total amount paid under this Plan arising out of the injury or illness for which the Participant or Covered Family Member (or the Participant's or Coverd Family Member's Guardian or Estate) has, may have or asserts a cause of action. In addition, this Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights under this Section.

22.03 **Responsibility of Participant or Covered Family Member**. The Participant or Covered Family Member on behalf of him or herself (or the Participant's or Covered Family Member's Guardian or Estate) specifically agrees not to do anything to prejudice this Plan's right to reimbursement or subrogation. In addition the Participant or Covered Family Member on behalf of him or herself (or the Participant's or Covered Family Member's Guardian or Estate) agrees to cooperate fully with the Plan in asserting and protecting the Plan's subrogation rights. The Participant or Covered Family Member on behalf of him or herself (or the Participant's or Covered Family Member's Guardian or Estate) agrees to execute and deliver all instruments and papers (in their original form) and to do whatever else is necessary to fully protect the Plan's subrogation rights. In addition, the Participant or Covered Family Member on behalf of him or herself (or the Participant's or Covered Family Member's Guardian or Estate) specifically agrees to notify the Plan in writing if any benefits are paid under the Plan that arise out of any injury or illness that provides or may provide the Plan subrogation rights under this Section.

22.04 **Failure to Comply With Requirements of This Section**. Failure to comply with the

requirements of this Section 22 by the Participant or Covered Family Member (or the Participant's or Covered Family Member's Guardian or Estate) may, at the discretion of the Trustees, result in a forfeiture of benefits under this Plan.

SECTION 23. GENERAL EXCLUSIONS AND LIMITATIONS

23.01. Notwithstanding any other provisions of this Plan, the following charges are excluded from coverage:

1. Care, supplies, or equipment not Medically Necessary, as determined by the Plan, for the treatment of an Injury or illness. The determination whether care, supplies or equipment are Medically Necessary shall be made by the Trustees, or their designee, in their absolute discretion and in accordance with the provisions of Section 19 of the Plan Document.

2. Services rendered or supplies provided before coverage begins, i.e., before a Participant's Effective Date, or after coverage ends. Such services and supplies shall include, but not be limited to Inpatient Hospital admissions which begin before a Participant's Effective Date, continue after the Participant's Effective Date, and are covered by a prior carrier.

3. Any services rendered or supplies provided while you are confined in a facility which does not meet the definition of "Hospital" as set forth at Section 1.12 of this Plan Document.

4. Any services rendered or supplies provided while you are a patient or receive services at or from an person or entity which does not meet the definition of "Health Care Provider" set forth at Section 1.11 of this Plan Document.

5. Any portion of a provider's fee or charge which is ordinarily due from a Participant, but which has been waived. If a provider routinely waives (does not require the Participant to pay) a Deductible or an Out-of-Pocket amount, the Claims Administrator will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.

6. Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law.

7. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.

8. Any item, service, supply or care not specifically listed as a Covered Service in this Plan Document.

9. Care given by a medical department or clinic run by your Employer.

10. Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.

11. Care of corns, bunions (except capsular or related surgery), calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.

12. Daily room charges while this Plan is paying for an Intensive Care, cardiac care, or other special care unit.

13. Vision therapy unless needed due to intraocular surgery.

14. Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or injury except those which may be specifically listed herein.

15. The following items related to Durable Medical Equipment are specifically excluded:

- Bed related items: bed trays, over the bed tables, bed wedges, custom bedroom equipment, nonpower mattresses, pillows, posturepedic mattresses, low air mattresses (powered), alternating pressure mattresses;
- Bath related items: bath lifts, nonportable whirlpool, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, spas;
- Chairs, Lifts and Standing Devices: computerized or gyroscopic mobility systems, roll about

chairs, geri chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if the patient is two-person transfer), vitrectomy chairs, auto tilt chairs and fixtures to real property (ceiling lifts, wheelchair ramps, automobile lift customizations);
- Air quality items: room humidifiers, vaporizers, air purifiers, electrostatic machines;
- Blood/injection related items: blood pressure cuffs, centrifuges, nova pens, needle-less injectors;
- Pumps: back packs for portable pumps;
- Dialysis Machines;
- Other equipment: heat lamps, heating pads, cryounits, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adapters, Enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, exercise equipment, diathermy machines.

16. Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain, except as specifically stated as Covered Medical Expenses. Transportation to another area for medical care is excluded except when Medically Necessary for a Participant to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.

17. Services provided by a rest home, a home for the aged, a nursing home or any similar facility.

18. Hearing Aids

19. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of Cosmetic Surgery, unless treatment relating to such consequences is medically necessary. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be medically necessary, are not covered.

• This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

• This exclusion does not apply to Breast Reconstructive Surgery.

20. Complications of non-covered procedures are not covered.

21. Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, nutritional counseling or dietary control. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it's the sole means of nutrition. Food supplements. Services of Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical or psychiatric care or counseling. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature. Procedures including but not limited to liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw.

22. Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction).

23. Transportation provided by other than a state licensed professional ambulance service, and ambulance services other than in a medical emergency.

24. Hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.

25. Advice or consultation given by any form of telecommunication.

26. Services and supplies for which you have no legal obligation to pay, or for which no charge has

been made or would be made if you had no health insurance coverage.

27. Charges for failure to keep a scheduled visit or for completion of claim forms; for Physician or Hospital's stand-by services; for holiday or overtime rates.

28. The following forms of therapy: vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne, services and supplies for smoking cessation programs and treatment for nicotine addiction, and carbon dioxide.

29. Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

30. Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

31. Services paid under Medicare or which would have been paid if the Participant had applied for Medicare and claimed Medicare benefits.

32. Those charges in excess of the usual, customary and reasonable amount for the area. A determination as to whether charges are excessive shall be made by the Trustees, or their designee, in their absolute discretion in accordance with the provisions of Section 19 of this Plan.

33. Services related to or performed in conjunction with artificial insemination, in-vitro fertilization or a combination thereof.

34. Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.

35. Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guests' meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.

36. Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation.

37. Injuries received while committing a crime.

38. Biomicroscopy, field charting or aniseikonic investigation.

39. Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.

40.Non-emergency treatment of chronic illnesses received outside the United States performed without authorization.

41.Any drug or other item which does not require a prescription.

42. Court-ordered services, or those required by court order as a condition of parole or probation.

43. Hypnotherapy.

44.Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

45.Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.

46. Specific medical reports, including those not directly related to treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

47. Thermograms and thermography.

48. Elective abortions.

49. Substance Abuse Treatment.

50. Private Duty Nursing.

51. Injuries incurred as a result of a suicide attempt, or intentionally self-inflicted injury while sane.

52. Custodial Care, domiciliary care, rest cures or travel expenses even if recommended for health reasons by a Physician.

53. Any item, service, supply or care not specifically listed as a covered service in this Plan.

54. Services or supplies not prescribed or directed by a Physician.

55. Court ordered examinations or care.

56. Stop smoking aids, or services of stop-smoking clinics.

57. Physical therapy to maintain motor functions unless there is a chance of improvement or reversal.

58. Conditions related to autistic disease of childhood, hyper-kinetic syndromes, learning disabilities, behavioral problems, mental retardation or hospitalization for environment changes.

59. Services provided by a family member or by a provider's employee to a co-worker.

60. Experimental or investigative procedures

61. Those charges for examination or tests for check-up purposes which are not incidental to and necessary for the treatment of illness or injury.

62. Charges for cosmetic corrective eye surgery.

63. Treatment of a Mental Health Disorder.

SECTION 24. FAMILY AND MEDICAL LEAVE

24.01 **Eligibility for Family and Medical Leave**. Eligibility for Family and Medical Leave is governed by the Federal Family and Medical Leave Act ("FMLA") which, in general, provides that eligible employees are entitled to up to twelve (12) weeks of unpaid leave for the following circumstances:

- The birth of a child of the Employee in order to care for such child;
- The placement of a child with the Employee for adoption or foster care;
- Caring for a spouse, child or parent who has a serious health condition;
- A serious health condition of the Employee which renders him or her unable to perform the functions of the position of such Employee.

Effective February 28, 2008 the FMLA also provides that eligible Employees who are a spouse, son, daughter, parent or next of kin, are entitled to up to 26 workweeks of unpaid leave to care for a "member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness."

Effective October 28, 2009, the FMLA also provides the eligible Employees whose spouse, son, daughter, or parent are on active duty, or call to active status as a member of the National Guard or Reserve in support of a contingency operation, are entitled up to twelve (12) weeks of unpaid leave for "qualifying exigencies" arising out of such active duty or call to active duty.

A determination as to whether an Employee is eligible for Family and Medical Leave is governed by the FMLA and not by the provisions of the Plan.

24.02 **Extension of Coverage in the Event an Employee is FMLA Eligible**.

If an Employee is eligible for and elects to take Family and Medical Leave under the FMLA by reason

of his or her own disability, he or she shall be entitled to an extension of benefits from the Plan for a period of two months from the date of their last contribution period, afterutilizing any period of leave covered by the FMLA. An Employee eligible for Family and Medical Leave under the FMLA need not apply for Continuation of Coverage under Section 15 of this Plan until the completion of any extension of benefits for up to two (2) months by reason of their own disability and any continuing period of disability covered by FMLA. Once such right to leave under FMLA has been exhausted, such Employee shall then be eligible for Continuation of Coverage as described at Section 15 of the Plan.

SECTION 25. ASSIGNMENT OF BENEFITS

All Medical and Dental benefits payable by the Fund shall be deemed assigned to the Health Care or Dental Provider in question by the affected Participant. Medical or Dental benefits shall not be paid directly to a Participant unless the Fund office receives satisfactory evidence that the bill of the Provider in question has been paid in full.

Any time a Participant is hospitalized or receives any form of dental or medical care, it is his/her responsibility to inform the Hospital or other Health Care or Dental Provider of the full extent of his/her coverage under this Plan.

ANNUAL BENEFIT PLAN

- Board of Trustees
- Part I: About the Benefit Plan
- Part II - Summary Plan Description & FAQ's
- Part III: Annual Benefit Plan Document
- Amendments
- Summary Annual Report
- What's New
- Contact the Benefit Plan

HEALTH & WELFARE PLAN

- Board of Trustees
- What's New
- Schedule of Benefits
- Part I: About the H&W Plan
- Part II: Summary Plan Description & FAQ's
- Part III: Plan Document
- Amendments
- Summary Annual Report
- Summary of Benefits & Coverage
- Grandfather Status
- Contact Health & Welfare Plan

PENSION PLAN

- Board of Trustees
- About the Pension Plan
- Part I - Summary Plan Description & FAQ's
- Part II: Your ERISA Rights
- Part III - Plan Document
- Amendments
- Summary Annual Report
- What's New
- Contact the Pension Plan

Privacy Statement Terms Of Use