IRONWORKERS LOCAL 11
BENEFIT FUNDS & TRAINING FACILITY

IRON WORKERS LOCAL 11

WELFARE FUND

SUMMARY PLAN DESCRIPTION (SPD)

JULY 1, 2015

WELFARE FUND ADDENDUM
Welfare Fund Benefit Changes to Dental and Vision Benefits
Effective March 1, 2016

The Board of Trustees is pleased to announce that the Fund will provide comprehensive PPO networks for the Fund's dental and vision benefits. These PPO networks will replace the existing benefits provided through the Fund for active participants and covered dependents, including those participants and dependents covered by Cobra, effective March 1, 2016. The benefits will be provided by two high-quality national companies, Delta Dental and Davis Vision. This notice provides an overview of the dental and vision benefits.

Dental Benefits

The Fund will begin offering PPO dental benefits through Delta Dental effective March 1, 2016. Delta Dental will be the program administrator and will handle many administrative services such as answering questions about coverage, claims and the payment of claims.

By selecting a Delta Dental PPO provider you will receive the maximum benefit. You are free to choose any dentist to receive dental care, but you will generally pay less when visiting a participating PPO dentist. Participating (In-Network) Delta Dental PPO dentists are paid directly by Delta Dental for covered services. Non-participating (Out-of-Network) dentists will bill you directly, and Delta Dental will reimburse you up to the in-network PPO schedule of allowances. You will be responsible for an annual deductible and applicable coinsurance as shown in the Benefit Summary below. You will also be responsible for any part of the dentist's charges that exceeds the calendar year maximum.

Dental Benefit Summary Benefit	Coverage In/Out-of Network (You Pay)	Coverage (Fund Pays)
Calendar Year Deductible • Per Person • Family Aggregate Maximum	 $50 $150	 $0 $0
Preventive & Diagnostic Benefits (No Deductible) • Exams, Cleanings & Bitewing X-rays (subject to two visits per year) • Fluoride Treatment (subject to two visits per year, children to age 15)	0%	100%
Remaining Basic Benefits (After Deductible) • Fillings, Extractions • Endodontics (root canal) • Periodontics, Oral Surgery • Sealants	0%	100%

Dental Benefit Summary Benefit	Coverage In/Out-of Network (You Pay)	Coverage (Fund Pays)
Crowns & Prosthodontics (After Deductible) • Crowns, Gold Restorations (over natural teeth) • Bridgework • Full & Partial Dentures • Repair of Dentures	30%	70%
Calendar Year Maximum (per patient)	Costs in excess of $2,000 Calendar Year Maximum	Up to $2,000 Calendar Year Maximum
Orthodontic Benefits, full comprehensive treatment (adult and children up until the end of the month the child attains age 26) • Lifetime Maximum (per patient)	0% Costs in excess of $4,200 Lifetime Maximum	100% Up to $4,200 Lifetime Maximum

Important: Effective March 1, 2016, bony impacted wisdom teeth extractions only, will be covered under the major medical carrier, Horizon Blue Cross Blue Shield Direct Access Plan. Claims will be processed based on the Direct Access Plan's usual and customary fee schedule. Wisdom Teeth extractions, which are not impacted will be covered under the Delta Dental PPO Plan. Delta Dental PPO claims will be processed based on the PPO fee schedule of the Plan.

To Find a Delta Dental PPO Dentist. If you do not have a Delta Dental PPO dentist, you can call 800-DELTA-OK (800-335-7265) to have a list of participating dentists located in your area mailed directly to your home or you can go to Delta Dental's website (www.deltadentalnj.com). When you go to the website, first click "Find a Dentist," then under Network Selection, click on **Delta Dental PPO,** and fill in your location information and other preferences.

When You Go to the Dentist. During your FIRST appointment, tell your dentist that you are covered under this program. Please show your Delta Dental ID Card upon your visit, which includes your Group Name, ID number and Group Number.

ID Cards. You will receive two Delta Dental ID cards in the mail along with a Welcome Packet in mid-February. The ID card will include your unique identification number, the Group Name and the Group Number. You can print additional ID cards from Delta Dental's website (www.deltadentalnj.com) or you can call Delta Dental at **800-452-9310** to request additional cards.

Delta Dental Mobile App. Delta Dental's mobile app gives you access to find a dentist, claims and coverage, your ID card and other helpful and fun tools right on your mobile device. You can download the app for free from the iTunes App Store or the Google Android App Store.

Questions About Your Dental Benefits? If you have any questions regarding your benefits, you may contact Delta Dental's customer service line (800-452-9310, Monday through Thursday, 8:00 a.m. to 6:30 p.m. EST and Friday, 8:00 a.m. to 5:00 p.m.). For questions concerning your eligibility and other general questions, you may contact the Fund Office at 973-376-7230.

Vision Benefits

The Fund will begin offering PPO vision benefits through Davis Vision on March 1, 2016. Davis Vision will be the program administrator for the vision benefit program.

You may receive vision care from any vision care provider you choose, but you will generally pay less when you see a Davis Vision provider. Participating providers will be paid directly by Davis Vision for covered services. Visionworks is a participating provider with Davis Vision. They have over 25 locations in New Jersey and have an average of 2,000 frames per store, of which 50% are name brands and exclusive fashion brands. Patients have a $180.00 frames allowance at all Visionworks locations. For Non-participating providers, Davis Vision will reimburse you up to the reimbursement schedule shown below. You will be responsible for any part of the charges that exceeds the reimbursement schedule.

Vision Benefit Summary

Benefit	Your In-Network Cost	Out-of-Network Reimbursement*
Exam with Dilation as Necessary	No Copay	N/A
Exam Options • Standard Contact Lens Fit and Follow-Up (Collection Contact Lenses)	No Copay	N/A
Frames (Any available frame at retail provider locations) Davis Vision Collection (in lieu of Allowance) available at private provider offices as well.	No Copay on any Fashion, Designer or Premier level frame from Davis Vision's Collection; $130 Allowance, 20% off balance over $130 toward any frame from the provider; ($180 allowance, 20% off balance over $180 at all Visionworks locations)	N/A
Standard Plastic Lenses		
• Single Vision	No Copay	N/A
• Bifocal	No Copay	N/A
• Trifocal	No Copay	N/A
• Lenticular	No Copay	N/A
• Standard Progressive Lens	$50 Copay	N/A
• Premium Progressive Lens	$90 Copay	N/A
• Ultra Progressive Lens	$140 Copay	N/A

Vision Benefit Summary

Benefit	Your In-Network Cost	Out-of-Network Reimbursement*
Lens Options		
• UV Treatment	$12	N/A
• Tinting of Plastic Lenses	No Copay	N/A
• Standard Plastic Scratch Coating	No Copay	N/A
• Scratch Protection Plan		
- Single Vision Lenses	$20 Copay	N/A
- Multifocal Lenses	$40 Copay	N/A
• Standard Polycarbonate - Adults	$30 Copay	N/A
• Standard Polycarbonate - Kids under 19 (dependent children, monocular patients and patients with prescriptions +/-6.00 diopters or greater)	No Copay	N/A
• Standard Anti-Reflective Coating	$35 Copay	N/A
• Premium Anti-Reflective Coating	$48 Copay	N/A
• Ultra Anti-Reflective Coating	$60 Copay	N/A
• Polarized Lenses	$75 Copay	N/A
• Photocromatic/Transitions Plastic	$65 Copay	N/A
• High-Index Lenses	$55 Copay	N/A
Contact Lenses (in lieu of eyeglasses) (Contact lens allowance includes materials only)		
• Evaluation, Fitting & Follow-up Care (applies to collection contact lenses)	No Copay	N/A
• Non-Collection Contact Lenses	$0 Copay; $130 allowance, 15% off balance over $130 at most locations[1]	N/A
• Disposable (Collection Contact Lenses) up to:	4 boxes/multipacks	N/A
• Planned Replacement up to:	2 boxes/multipacks	N/A
• Standard and Specialty Lens	15% discount at most locations[1]	N/A
Laser Vision Correction	**Up to $3,500 lifetime maximum benefit for the member / additional $3,500 lifetime maximum per one spouse / dependent age 23 and over only (pre-authorization required)	**Up to $3,500 lifetime maximum benefit for the member / additional $3,500 lifetime maximum per one spouse / dependent age 23 and over only (pre-authorization required)
Frequency:		
• Examination	Once every 24 months	
• Lenses or Contact Lenses	Once every 24 months	
• Frame	Once every 24 months	

[1] Except Walmart, Sam's Club or Costco locations

**** Member Reimbursement for Out-of-Network services will be 100% of charges up to $250 per covered person every two years combined for eye examinations, lenses and frames. You can go to any licensed vison provider that you choose and submit an itemized statement and Direct Reimbursement Claim Form to Davis Vision for reimbursement; or, you can take the Direct Reimbursement Claim Form with you at the time of visit and have the out-of-network licensed vision provider complete his portion of the form.***

*****For in-network or out-of-network laser vision correction, the Plan will pay 100% of charges up to a $3,500 lifetime maximum benefit per member and one dependent over the age of 23 (pre-authorization required).***

Plan Exclusions

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes or supporting structures;
- Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- Plano (non-prescription) lenses and/or contact lenses;
- Non-prescription sunglasses;
- Two pair of glasses in lieu of bifocals;
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order;
- Services or materials provided by any other group benefit plan providing vision care;
- Lost lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Davis Vision provides a one year breakage warranty for the repair or replacement of your plan covered spectacle lenses, collection frame or frame from a network retail location where the collection is not displayed.

To Find a Davis Vision Provider (including Visionworks). Go to Davis Visons's website (www.davisvision.com), click on "Provider," and sign in to locate a provider.

ID Cards. – You will receive two ID Cards from Davis Vision along with a Welcome Packet in mid-February. Additional ID Cards can be printed from their website (www.davisvision.com) or by calling Davis Vision at 800-278-7753.

Questions About Your Vision Benefits? If you have any questions regarding your benefits, you may contact Davis Vision at 800-278-7753. For questions concerning your eligibility and other general questions, you may contact the Fund Office at 973-376-7230.

Questions?

If you have questions about these new provisions or your benefits in general, please contact the Fund Office at 973-376-7230.

Statement of Grandfathered Status

The Iron Workers Local 11 Welfare Fund believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 973-376-7230. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

ERISA Information

Plan Sponsor:	Board of Trustees of the Iron Workers Local 11 Welfare Fund
Sponsor’s EIN #:	226041517
Plan Number:	501

IRON WORKERS LOCAL 11 WELFARE FUND

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The Iron Workers Local 11 Welfare Fund is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees with equal voting power.

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I. ACTIVE EMPLOYEES BENEFITS

The Iron Workers Local 11 Welfare Fund (the "Fund" or "Plan") is designed to help members and their eligible dependents afford proper health care. The Fund also provides members with disability, life and accident insurance coverage.

Medical (for you and your eligible dependents)

In-Network

When you go In-Network for your care, the Plan generally pays 90% of the Plan allowance for hospital care and other Basic expenses that do not require a copayment. There is a $25 copayment for Primary Care Office Visits and $30 copayment for Specialist Office Visits. After you pay a $500 Individual/$1,000 Family annual deductible, the Plan also pays 80% of the Plan allowance for Supplemental expenses (such as ambulance service). There is no lifetime maximum benefit for In-Network expenses.

Out-of-Network

When you go Out-of-Network for your care, the Plan pays 70% of the Plan allowance for facility charges and 70% for all other eligible expenses after you pay a $500 Individual/$1,000 Family annual deductible. There is no lifetime maximum benefit for Out-of-Network expenses.

Prescription Drug (for you and your eligible dependents)

Retail

When you fill your prescriptions at your local pharmacy, you'll pay 10% of your eligible prescription drug expenses, with a $5 minimum and a $75 maximum payment per generic prescription. You can get up to a 30-day supply per prescription.

Mail Order

When you fill your prescriptions through the Prescription Plan's Mail Order Program, Benecard PBF, you'll pay 10% of your eligible prescription drug expenses, with a $10 minimum and a $150 maximum payment per prescription. You can get up to a 90-day supply per prescription.

Specialty Prescriptions

When you fill your prescriptions through the Prescription Plan's Specialty Program, Benecard PBF, you'll pay 10% of your eligible prescription drug expense, with a $50.00 minimum and a $100.00 maximum payment per prescription. You can get up to a 30-day supply per prescription.

Prescription Copayments

Retail Pharmacy – 30 Day Supply (No Annual Maximum or Deductible)

- 10%; $5.00 minimum, $75.00 maximum for generic prescriptions
- 10%; $15.00 minimum, $75.00 maximum for formulary prescriptions
- 10%; $30.00 minimum, $75.00 maximum for non-formulary prescriptions

Mail Order Pharmacy – 90 Day Supply (No Annual Maximum or Deductible)

- 10%; $10.00 minimum, $150.00 maximum for generic prescriptions
- 10%; $30.00 minimum, $150.00 maximum for formulary prescriptions
- 10%; $60.00 minimum, $150.00 maximum for non-formulary prescriptions

Specialty Pharmacy – 30 Day Supply (No Annual Maximum or Deductible)

- 10%; $50.00 minimum, $100.00 maximum per prescription

* For all pharmacies, brand name prescriptions that have a generic equivalent, the participant is responsible for the 10% copayment plus the price difference of the brand name and generic.

Dental (for you and your eligible dependents)

The Plan pays the scheduled amount (see page 56) for eligible dental expenses. For orthodontia treatment, there's a separate lifetime maximum benefit of $4,200.00.

Vision Care (for you and your eligible dependents)

The Plan pays 100% of eligible vision care expenses, up to a maximum benefit of $250 every two years. Benefits for laser vision surgery are available to the member and one dependent over the age of 23, up to a lifetime maximum benefit of $3,500 per person.

Hearing Aid (for you and your eligible dependents)

The Plan pays 100% of eligible hearing aid expenses, up to a maximum benefit of $1,200 per ear every three years. Benefits are available for hearing exams and testing and up to two appliances every three years.

Short-term Disability (for you only)

If you are unable to work due to an injury or illness, the Plan pays $120 a week for up to 26 weeks of disability.

Long-term Disability (for you only)

If you become totally and permanently disabled due to a non-work-related injury or illness, the Plan pays $400 a month.

Life Insurance (for you only)

The Plan provides $30,000 of life insurance coverage.

Accidental Death & Dismemberment (AD&D) Insurance (for you only)

The Plan pays $30,000 to your beneficiary if you die in an accident (in addition to the Life Insurance benefits described above), or to you if you are dismembered or lose your eyesight in an accident. The amount payable depends on the severity of the accidental loss.

Supplemental Accidental Death

The Plan pays an additional amount of $70,000 to your beneficiary if you die on the job-site as a result of a fatality.

Contributing employers pay the full cost of the Fund and make all contributions. Employee contributions are neither required nor allowed. Employer contributions are based on the rate(s) specified in applicable collective bargaining agreements, and take the form of Benefit Vouchers that employers buy from the Fund. The Benefit Voucher you get in your pay envelope every pay period shows the total value of fringe benefit contributions made to all Funds on your behalf; the Welfare Fund portion of the Voucher shows you what our employer is paying for your Plan coverage on your behalf.

Life Insurance - If You Become Disabled

If you become totally and permanently disabled because of injury or illness while insured, your life insurance will remain in force for up to 36 months after your 26 weeks of short term disability coverage has ended, as long as you remain so disabled. Periodically, proof of disability will be required by the Fund Office.

Death Benefits for Retirees

In the event of your death, a $7,500 Death Benefit will be paid to your beneficiary if you had 15 Pension Credits and retired prior to 4/1/1994. If you retired on or after 4/1/1994 and had 25 Pension Credits or 15 Pension Credits and a Social Security Disability Award, a $7,500 Death Benefit will also be paid to your beneficiary. The Death Benefit is not Life Insurance - it is a taxable benefit paid by the Iron Workers Local 11 Welfare Fund and a 1099 is issued to the beneficiary at the end of the year. To report a member’s death, inquire about a Death Benefit Claim or to get additional information, please call the Fund Office at 973-376-7230.

Keeping the Fund Informed

1. The best way to ensure fast and accurate benefit payment and other services from the Fund Office is to make sure they have the most up-to-date information for you. In particular, please contact the Fund Office whenever you or your spouse:

- **a)** changes name
- **b)** changes address
- **c)** changes telephone number or e-mail address
- **d)** changes marital status (marriage, separation or divorce)
- **e)** dies
- **f)** gains or losses other health care coverage
- **g)** becomes eligible or ineligible for Medicare (including Medicare disability benefits).

2. You also must contact the Fund Office whenever a dependent child becomes eligible (birth, adoption) or ineligible (reaches age 26).

This section of your handbook is the Summary Plan Description ("SPD") for the Welfare Fund as of July 1, 2015. It's meant to help you understand how the Plan works. It doesn't change the official rules and regulations in the official Plan document or other documents, including trust agreements and the collective bargaining agreements establishing the Plan. Rights to benefits are determined only by referring to the full text of official Plan documents (available for your inspection at the Fund Office) or by official action of the Board of Trustees. If there is any conflict between the terms of the official rules and regulations of the Welfare Fund and this section, the official rules and regulations shall control. In addition, the Board of Trustees reserves the right, in its sole and absolute discretion, to amend or end this Plan at any time, subject to the terms of the applicable collective bargaining agreements.

II. ELIGIBILITY AND PARTICIPATION

A. When Your Participation Begins

1. You become a participant in the Iron Workers Local 11 Welfare Fund on the first day of the month after you work at least 1,000 hours in covered employment during a 12-month period. However, you are not eligible for Long-term Disability benefits until the first day of the month after you work at least 200 hours in covered employment per quarter for 12 consecutive calendar quarters. However, if you are a "full time employee" (as defined under the Patient Protection and Affordable Care Act) of the Iron Workers Local 11, Iron Workers Local 11 Welfare Fund or the Ironworkers Local 11 Benefits Fund and Training facility, you will become a participant in the Iron Workers Local 11 Welfare Fund on the first day of the second month following a one month orientation period (that is, first day of the month following three calendar months of employment).

2. Covered employment. "Covered employment" is work for which your employer is required to contribute to the Welfare Fund, according to the terms of a collective bargaining agreement between your employer and Iron Workers Local 11 of the International Association of Bridge, Structural and Ornamental and Reinforcing Ironworkers, AFL-CIO. Covered employment also may include work by the following employees if their employers contribute to the Plan on their behalf:

a) officers or full-time employees of Iron Workers Local 11
b) full-time employees of the Iron Workers Local 11 Welfare Fund or the Ironworkers Local 11 Benefit Funds and Training facility.

3. If your employment is interrupted. If you leave covered employment and return within 12 months from when your coverage lapses, your coverage starts again on the first day of the month after you work at least 200 hours in covered employment for three consecutive months. If you leave covered employment and your coverage lapses for more than 12 months, you will be treated as a new participant and must again satisfy the requirements specified in section IIA, paragraph 1.

4. If you're working in another jurisdiction. Under the Iron Workers International Reciprocal Health and Welfare Agreement, you can maintain your eligibility for benefits under this Fund while you're working in the jurisdiction of another health fund, as long as the other health fund is considered a Cooperating Fund. To maintain your eligibility, the Cooperating Fund must transfer employer contributions it has received on your behalf to this Fund (the Home Fund), according to the terms of the reciprocity agreement. As long as they make this transfer, hours of service with a Cooperating Fund(s) will be considered service with our Fund for eligibility purposes, regardless of the dollar amount of the contributions transferred.

B. When Dependent Participation Begins

1. Your eligible dependents become participants in the Iron Workers Local 11 Welfare Fund when your participation begins, and their participation will continue for as long as you remain a participant and they remain eligible dependents. Your eligible dependents include your lawful spouse and your children (married or unmarried) under the age of 26.

Child means your biological child or legally adopted child. It also includes a child placed with you for adoption awaiting finalization of the adoption. You are required to submit written proof of your child's age and relationship to you to the Fund Office (notarized copy of birth certificate and copy of social security card).

2. For the most part, your dependents are covered for the same benefits as you, but there are exceptions (such as Disability, Life and AD&D Insurance benefits).

Disabled children over age 26. Extended coverage is available for an unmarried child who is over age 26, who is (i) physically or mentally disabled; (ii) incapable of self-sustaining employment due to a physical or mental disability; (iii) solely dependent of you for support; (iv) became so disabled before reaching age 19; and (v) was covered under the Plan at that time. You must submit written proof of incapacity to the Fund Office within 31 days of the date the child's eligibility would have otherwise ceased and from time to time thereafter, as required by the Trustees.

CALLOUT: You cannot be covered both as a member and as a member's dependent. Dependents of two members can be covered as a dependent of only one of them.

C. When Your Participation Ends

1. Your Fund participation ends at the end of the calendar quarter following the calendar quarter in which you work fewer than 200 hours in covered employment. If your participation was extended during a disability (as described below), it ends when you no longer meet the Fund's definition of "permanently and totally disabled" or, if your disability began after 50, when you reach age 65 and become Medicare-eligible.

CALLOUT: Keep in mind that you and/or your dependents may be able to continue coverage under COBRA after Fund participation otherwise would end (see page 14).

2. If you have worked over 100, but less than 200, hours in covered employment during a calendar quarter in any of the two calendar quarters prior to your benefits terminating, you have the option to purchase the remaining hours at the applicable hourly Plan contribution rate. You may only exercise this "self-payment" option once every 12 months.

D. When Dependent Participation Ends

1. Dependent participation generally stops when yours does (as described) or when a dependent is no longer eligible, whichever happens first. (For example, your spouse's coverage will end if you and your spouse divorce).

2. Coverage for you and/or your dependents maybe terminated retroactively (rescinded) due to any of the following:

- **a)** in cases of fraud or intentional misrepresentation (in such cases, you will be provided with 30 days' notice)
- **b)** due to non-payment of premiums (including COBRA premiums).

Failure to provide complete, updated and accurate information to the Fund Office on a timely basis regarding your marital status, employment status of a spouse or child, or the existence of other coverage constitutes intentional misrepresentation of material fact to the Plan.

E. Continued Coverage During Disability

1. If you are totally and permanently disabled as an ironworker at the time Fund participation would otherwise end, all welfare benefits offered under the Fund will be continued for you and your eligible dependents for three years after participation would otherwise end or you stop being totally and permanently disabled, whichever happens first.

F. Coverage For Your Family After Your Death

1. If you die while covered, continued coverage for your family depends on the number of years you were continuously covered and your age, among other factors:

- **a)** If you were covered continuously under the Fund for at least five years and died after you reached age 52 and earned at least 25 Pension Credits under the Iron Workers Local 11 Pension Fund, dependent coverage will be continued for up to 5 years (with COBRA running concurrently).

b) If you were covered continuously under the Fund for at least five years and died before you reached age 52, dependent coverage will be continued for up to 5 years (with COBRA running concurrently).

c) If you don't meet either set of requirements specified above, dependent coverage will be available under COBRA benefits.

2. Your surviving spouse's coverage will end sooner if she/he remarries or becomes eligible for Medicare. A dependent child's coverage will end sooner if she/he no longer meets the definition of an eligible dependent child, as specified on page 12.

G. Continued Coverage During a Military Leave of Absence

If you are on active military duty for 31 days or less, you will continue to receive medical coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you are on active duty for more than 31 days, USERRA permits you to elect COBRA continuation coverage for you and your dependents at your own expense for up to 18 months. (See below for more information on COBRA.)

1. When you return to work after receiving an honorable discharge, your full eligibility will be reinstated on the day you return to work with a participating employer, provided that you return to employment within one of the following time frames:

a) 90 days of the date of discharge if the period of military service is more than 180 days

b) 14 days from the date of discharge if the period of military service was 31 days or more but less than 180 days

c) at the beginning of the first full regularly-scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

2. If you are hospitalized or convalescing from an injury resulting from active duty, these time limits may be extended for up to two years. Contact the Fund Office for more details.

H. Continued Coverage Under COBRA

1. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), requires that the Plan offer you and your family the opportunity for a temporary extension of health care coverage at group rates in certain instances where coverage under the Plan would otherwise end (called "qualifying events"). Continued coverage under COBRA applies to the medical, dental, vision care and prescription drug benefits described in this

booklet. You don't have to prove good health to get COBRA coverage. However, you are required to pay the full cost of coverage for both you/or and any covered dependents (plus a 2% administrative fee).

2. The benefits under COBRA are the same as those covering people who are not on continuation coverage. You should also keep in mind that each individual entitled to coverage as the result of a qualifying event has a right to make his or her own election of coverage. For example, your spouse may elect COBRA coverage even if you do not. COBRA eligible members are not eligible for Short-Term Disability Benefits and/or Life Insurance Benefits.

3. Qualifying COBRA events. The chart on page 16 shows when you and your eligible dependents may qualify for continued coverage under COBRA, and how long your coverage may continue.

4. Newborn children. If you have a newborn child, adopt a child, or have a child placed with you for adoption while your continued coverage under COBRA is in effect, you may add the child to your coverage. To add coverage for the child, notify the Fund Office within 30 days of the child's birth, adoption or placement for adoption. Legal proof of your relationship to the child must also be provided.

5. Multiple qualifying events. If your covered dependents experience an additional qualifying event while COBRA coverage is in force, they may be eligible for an additional period of continuation coverage not to exceed a total of 36 months from the date of the first qualifying event. For example, if your employment ends, you and your covered dependents may be eligible for 18 months of continued coverage. During this 18-month period, if you die (a second qualifying event), your covered dependents may be eligible for an additional period of continuation coverage. However, the two periods of coverage combined may not exceed a total of 36 months from the date of the first qualifying event (your termination).

COBRA CONTINUATION OF COVERAGE		
FOR THIS QUALIFYING EVENT…	**COVERAGE MAY CONTINUE FOR**	**MAXIMUM DURATION OF COVERAGE**
Your employment terminates for reasons other than gross misconduct (including military leave)	You and your eligible dependents	18 months[1]
You become ineligible for coverage due to a reduction in your employment hours	You and your eligible dependents	18 months[1]
You die	Your eligible dependents	36 Months
You divorce or legally separate	Your eligible dependents	36 months
Your dependent child no longer qualifies as an eligible dependent (for example, she/he reaches age 26)	Your eligible child	36 months
You become entitled to Medicare	Your eligible dependents	36 months

[1]Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, become totally disabled within the meaning of Title II or Title VXI of the Social Security Act. This additional 11 months is available to employees and enrolled dependents if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage. Additionally, coverage can be extended for eligible dependents to a maximum of 36 months in the event of death or Medicare entitlement of the employee or divorce or legal separation.

6. Notice of COBRA eligibility. You and/or your family are responsible for notifying the Fund Office of your death, termination of employment, reduction in hours of employment or Medicare entitlement no later than 60 days after your loss of coverage due to one of these events.

7. You or your eligible dependents are responsible for informing the Fund Office of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the date of the event. If you do not notify the Fund by the end of that period, your dependents will not be entitled to continuation coverage. The Fund must notify you and/or your covered dependents of your right to COBRA coverage within 14 days after it receives notice or becomes aware that a qualifying event has occurred. You will have 60 days to respond if you want to continue coverage – measured from the date coverage would otherwise end or, if later, the date the COBRA notice is sent to you. An individual who becomes entitled to Medicare after COBRA is elected will have his or her continuation coverage terminated prior to the end of the maximum continuation period.

8. Procedures for providing notice to the Fund. You (the participant and/or eligible dependents) must give the Fund Office notice as soon as possible, but no later than the applicable deadline set out above, for these events:

- **a)** divorce or legal separation
- **b)** a child ceasing to be a dependent
- **c)** a second qualifying event that entitles an eligible dependent to additional COBRA coverage
- **d)** a dependent is determined to be disabled under Social Security
- **e)** a dependent who had been disabled under Social Security receives notice that he or she is no longer considered disabled.

9. Send your notice to:
Iron Workers Local 11 Welfare Fund
12 Edison Place
Springfield, NJ 07081

10. Please include all of the following in your notice:

- **a)** your name
- **b)** the names of your dependents
- **c)** your Social Security number and the Social Security numbers of your dependents
- **d)** your address
- **e)** the nature and date of the occurrence you are reporting to the Fund.

11. Paying for COBRA Coverage. You have to pay the full cost of continued coverage under COBRA plus a 2% administrative fee. If you are eligible for 29 months of continued coverage due to disability, you must pay 150% of the full cost of continued coverage during the 19th to 29th months of coverage. The following rules apply in making your COBRA payments.

a) It is easiest to make your **first payment** when you file your COBRA election, that is, within 60 days from the date your Plan coverage would otherwise end. In no event may your payment be made later than 45 days from the date you mail your signed election form to the Fund Office. Your first check should cover the period from the date your group coverage ended (and COBRA coverage began) **through** the current month.

b) All subsequent payments after the first payment will be due on the first day of each month for that month's coverage (for example, by June 1 for June coverage). Keep in mind that the Fund Office does not send monthly bills or reminders for COBRA coverage and it is your responsibility to see that your payment is at the office by the due date. In no event, may your payment be made more than 30 days from the due date or your coverage will terminate.

c) COBRA premiums are generally reviewed at least once a year and are subject to change. You will be notified by the Fund Office if the amount of your monthly payment changes.

12. You should also be aware that if benefits change for active employees, your coverage will change as well.

13. Costs may change from year to year. You will be notified by the Fund Office if the amount of your monthly payment changes.

CALLOUT: If you fail to notify the Fund Office of your decision to elect COBRA continuation coverage or you fail to make the required payment, your Fund health coverage will end.

14. When COBRA coverage ends. Your continued coverage under COBRA may end for of the following reasons:

a) You have continued coverage for the maximum 18, 29 or 36 month period.

b) The Plan terminates. If the coverage is replaced, you may be continued under the new coverage.

c) Non-payment of premiums. Your coverage will terminate the last day of the month for which premiums were paid.

d) You become covered under another group health plan.

e) You are continuing coverage during the 19th to 29th months of a disability, and the Social Security Administration determines you are no longer disabled.

f) You or a covered dependent becomes entitled to Medicare.

15. Once your COBRA coverage ends for any reason, it cannot be reinstated.

CALLOUT: Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for trade adjustment assistance under a federal law called the Trade Act of 1974. If you have any questions regarding the Trade Act or if you are not sure whether you qualify for trade adjustment assistance, you may call the Health Care Tax Credit Customer Contact Center toll- free at 1-888-628-4282. TTD/TTY callers may call toll-free at 1-866- 626-4282. More information about the Trade Act is also available at www.doleta.gov.tradeact/2002act_index.asp.

16. Full details of COBRA continuation coverage will be furnished to you or your eligible dependents when the Fund Office receives notice that a qualifying event has occurred. It is important to contact the Fund Office as soon as possible after one of these events occurs.

III. HOW MEDICAL EXPENSES ARE PAID

The Plan pays benefits for eligible medical expenses incurred in the United States based on whether your care is considered “In-Network” or “Out-of-Network.”

A. In-Network

1. In-Network benefits apply only to services and supplies that are both covered by the Plan and provided or authorized by a Horizon Blue Cross Blue Shield Direct Access network provider. The network provider will assess your medical need and advise you on appropriate care, as well as take care of any necessary tests, utilization management or hospital admissions.

- **a) Basic.** When you use a doctor, hospital or other provider in the network, the Plan generally will pay 90% for most Basic services and supplies, including hospitalization. You will not have to satisfy a deductible — you will pay the remaining 10%, subject to $500 out of pocket maximum per person/per year and a $25 copayment for doctor visits, $30 co-payment for specialist visits.
- **b) Supplemental.** Supplemental services and supplies are generally covered at 80% of the Plan allowance after you satisfy the annual deductible (as described on pages 41-42).

2. About the network. Horizon BCBSNJ has carefully selected the physicians, hospitals and other providers who participate in their Direct Access network. Each physician in the network holds a current, unrestricted license from the appropriate state and federal authorities; has admitting privileges and is a member in good standing at a network hospital; is Board- certified or Board-eligible; and provides proof of sufficient malpractice insurance and a satisfactory malpractice history.

3. Using network providers. When you visit the provider you’ve selected, show him/her your Horizon Blue Cross Blue Shield Direct Access card. When you identify yourself to network providers with your Direct Access card, they will file all claims for you and the Plan will pay them directly. Network providers are listed on the Horizon BCBSNJ website at www.horizonblue.com.

B. Out-of-Network

1. Care that is not provided by a network provider is considered Out-of- Network care and, as such, reimbursed at a lower level. If you use non-network providers, you must first satisfy the annual deductible before being reimbursed a percentage of the Plan allowance. Amounts above the allowance are not eligible for reimbursement and are your responsibility to pay, in addition to any deductibles or required co-insurance.

C. Annual Deductible

1. Each participant and dependent must satisfy the $500 (individual)/$1,000 (family) annual deductible before benefits become payable for In-Network Supplemental or all Out-of-Network care.

2. The following expenses are not applied toward the annual deductible:

- **a)** In-Network copayments
- **b)** expenses that are over the Plan allowance
- **c)** amounts that you pay because you failed to pre-certify a hospital stay or meet any other similar requirements
- **d)** charges excluded or limited by the Plan (see page 43).

3. Common accident deductible. If two or more family members are injured in the same accident and require medical care, the family must meet only one individual deductible.

4. Carry-over deductible. Any eligible expenses you incur during the last three months of the year that are applied to the out-of-network deductible will also be applied to the next year's out-of-network deductible.

D. Co-insurance

1. Once the annual deductible is met, the Plan pays 70% of the allowance for eligible Out-of-Network physician and facility expenses and 80% of the allowance for eligible In-Network and Out-of-Network Supplemental expenses. You pay the remaining 30% /20%, which is your co-insurance, plus any amounts over the allowance. Keep in mind that there is no coverage for any service or supply that is not considered medically necessary.

E. Your PPO Benefits Out-of-Area

1. When you travel outside the Horizon Blue Cross Blue Shield Direct Access network service area, you can go to a provider who participates with another Blue Cross and/or Blue Shield Plan (a "local Blue Plan"). Coverage outside of New Jersey and anywhere in the country is provided through the Blue Card PPO Program.Just show your Horizon Blue Cross Blue Shield Direct Access card to a participating provider and comply with the other terms in the certificate of coverage when receiving these services. Call 800-355-BLUE (2583) or go to the Horizon BCBSNJ website at www.horizonblue.com for more information.

IV. MEDICAL BENEFITS

A. Understanding What's Covered

1. The Plan considers the medical services and supplies described beginning on page 29 to be eligible for reimbursement, and reimburses specific medical expenses that result from a non-occupational illness or injury[1]. As you read the following pages, you'll see that most hospital, surgical and medical services are considered covered expenses. But certain services are not covered (as described starting on page 43), or are only partially covered.

2. Charges must be necessary and appropriate. To be considered for reimbursement, charges under the medical benefits portion of the Plan must be reasonable charges for the care of a covered person as the result of an injury, pregnancy or sickness. Any portion of a charge that the Fund considers to be unreasonable will not be considered for reimbursement. In addition, the Plan will pay benefits only for services and supplies considered to be medically necessary and appropriate, which generally means that they are all of the following:

- **a)** consistent with the symptoms or diagnosis and treatment of the patient's condition, illness or injury
- **b)** provided for the diagnosis, or the direct care and treatment, of the patient's condition, illness or injury
- **c)** meet the standards of generally accepted medical practice
- **d)** not solely for the convenience of the patient, the family or the provider
- **e)** the most appropriate level of service that can be safely provided to the patient
- **f)** accepted by a professional medical society in the United States as beneficial for the control or cure of the illness or injury being treated
- **g)** furnished within the framework of generally accepted methods of medical management currently used in the United States.

CALLOUT: The fact that a network provider may have prescribed, recommended or approved a service, supply or equipment does not, in itself, make it medically necessary.

3. Charges must not be more than the allowance. For the purpose of determining reimbursements under the Plan, the Allowance for any supply or service shall be an amount stipulated by the Plan as the most it will pay for a given procedure or the provider's actual charge, whichever is less.

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[1] Medical expenses for a job-related illness or injury are normally covered by Workers' Compensation. For more information about filing a Workers' Compensation claim, contact your employer.

4. Charges must be incurred while covered. The Plan will not reimburse any expenses incurred by a person while such person is not covered under the Plan.

5. All required documents by the Fund must be submitted within a one year period of the date of claim or the claim will be denied.

6. Automobile Accidents. No payment shall be made under this Welfare Fund and Plan in any event for charges sustained as a result of an automobile accident for which no-fault or other automobile insurance is responsible. This means that effective as of January 1, 1985, all participants of the Welfare Fund shall designate their motor vehicle insurer as the primary insurer within the meaning of any State's Motor Vehicle Insurance Act including New Jersey's Fair Automobile Insurance Act of 1990 for payment of any medical expenses as a result of a motor vehicle accident. The Welfare Fund shall be liable, in accordance with its program, solely as the secondary insurer for such services. In the event that a participant has the option and refuses or fails to designate the motor vehicle insurer as the primary insurer for payment of such services, the Welfare Fund shall not pay any claim arising out of a motor vehicle accident that would otherwise have been paid by the motor vehicle insurer, had said carrier been designated as the primary insurer for the payment of the above described services.

7. The Welfare Fund is secondary coverage for any illness or injury claims resulting from accidents incurred as an operator of a motorcycle, moped, terrain vehicle, snowmobile, jet ski or similar type of motorized equipment. A Lifetime Maximum benefit of $25,000.00 applies as secondary coverage.

B. Benefit Limits

1. There is no lifetime maximum benefit for In-Network or Out-of-Network expenses. However, there are dollar and/or frequency limits that apply to certain covered services. If a limit applies, it will be spelled out where a covered service is explained.

C. Utilization Management

1. The Plan requires certain kinds of medical care to go through the Horizon BlueCross Blue Shield of New Jersey (Horizon BCBSNJ) utilization management process in order for maximum benefits to be payable. Utilization management limits your exposure to unnecessary medical and financial risk by confirming the need for proposed and ongoing treatment. When you use a network provider, the network provider generally handles utilization management for you; when you go Out-of-Network, utilization management becomes **your** responsibility.

2. When utilization management is required. Your doctor, must contact Horizon BCBSNJ to review the following medical services and supplies:

- **a)** planned admissions to hospital or other facility
- **b)** ongoing hospitalization and discharge planning
- **c)** the surgical procedures listed on page 26
- **d)** outpatient hospital care

3. To make arrangements for utilization management, your doctor can call Horizon BCBSNJ at 800-355-2583. For non-urgent requests, he can reach them from 8:30 AM to 5:00 PM, Monday through Friday. For urgent requests, there is 24 hour coverage through their on-call program. It's expected that when he calls, he will do so within the following time frames:

- **a)** scheduled hospital admissions and/or surgical procedures: at least five business days in advance or as soon as the care is scheduled, if earlier
- **b)** pregnancy: at least 60 days before the baby's due date.

CALLOUT: To pre-certify mental health treatment or alcohol or substance abuse treatment, you must go through MHN – not Horizon BCBSNJ. **See page 49 for more information.**

4. Pre-admission review. If you plan to use a Direct Access network hospital, the hospital will make all necessary arrangements for pre-admission review. If you plan to use an Out-of-Network hospital, **you** must notify Horizon BCBSNJ of the hospital admission.

5. Once Horizon BCBSNJ is notified, they determine the medical necessity and appropriateness of the hospital admission, the anticipated length of stay and the appropriateness of health care alternatives, like home health agency care or other outpatient or out-of-hospital care. Horizon BCBSNJ notifies you or your provider, by phone, of the outcome of their review. If a review results in a denial, Horizon BCBSNJ will confirm that outcome in writing.

6. If Horizon BCBSNJ authorizes a hospital or other facility admission, the authorization is valid for:

- **a)** the specified provider
- **b)** the named attending practitioner
- **c)** the specified admission date
- **d)** the authorized length of stay
- **e)** the diagnosis and treatment plan.

7. The authorization becomes invalid and your Admission must be reviewed by Horizon BCBSNJ again if any of the following happens:

- **a)** you enter a facility other than the specified facility
- **b)** you change attending practitioners
- **c)** more than 30 days elapse between the time you obtain authorization and the time you enter the hospital or other facility, except in the case of a maternity admission (this time frame is seven days for mental illness and substance abuse)
- **d)** your condition or treatment plan changes.

8. Continued stay review. You or your provider must initiate a continued stay review whenever it is medically necessary and appropriate to change the authorized length of an inpatient stay. This must be done before the end of the previously authorized length of stay. In the case of an admission, the continued stay review determines the medical necessity and appropriateness of admission, the anticipated length of stay and extended length of stay, and the appropriateness of health care alternatives. Horizon BCBSNJ will notify the practitioner and facility by phone of the outcome of the review, including any newly authorized length of stay, and will also follow up with a written notice if the extended stay request is denied.

9. Horizon BCBSNJ may conduct its own continued stay review of any inpatient admission. If they do, they may contact your practitioner or facility by phone or in writing.

CALLOUT: The Plan does not cover any charges for inpatient services or supplies that are not authorized by continued stay review.

10. If you don't go through pre-admission or continued stay review. If you don't comply with the requirements outlined above within the specified timeframes, benefit payments will be reduced by 50%. That is, benefits will be reduced in all of the following circumstances:

- **a)** you or your provider do not request a pre-admission review at least five business days in advance or as soon as the care is scheduled, if earlier (at least 60 days in advance for a maternity admission)
- **b)** Horizon BCBSNJ authorization becomes invalid and you or your provider do not obtain a new one
- **c)** you or your provider do not request a continued stay review when necessary
- **d)** you or your provider do not receive an authorization for such continued stay
- **e)** you do not otherwise comply with all the terms of your group's Plan.

11. If the admission or procedure is not medically necessary, no benefits are payable. Also note that amounts you pay for failure to comply with pre- admission or continued stay review requirements do not apply to the Plan's deductibles, co-insurance limits, copayments or benefit maximums.

12. Second Opinions (Voluntary). You can get a voluntary second opinion whenever any of the following surgical procedures are recommended:

- **a)** adenoidectomy
- **b)** arthroscopy, knee with meniscectomy - examination of a joint using a scope
- **c)** cardiac catheterization
- **d)** carpal tunnel syndrome
- **e)** cholecystectomy with cholangiography or with exploration of common duct - removal of gall bladder (examination of bile ducts)
- **f)** coronary artery bypass graft - insertion of a vein graft to bypass an obstructed coronary artery
- **g)** coronary artery angioplasty
- **h)** excision of intervertebral disk - removal of a herniated disk (including excision of disk with fusion)
- **i)** hip replacement
- **j)** human organ and bone marrow transplant (subject to review to determine eligibility)
- **k)** hysterectomy: abdominal or vaginal - removal of the uterus
- **l)** knee replacement
- **m)** lower back surgery (and any other lower back inpatient care)
- **n)** mastectomy: radical, modified radical, unilateral or bilateral - surgical removal of breast (or portion)
- **o)** meniscectomy, knee - removal of cartilage from knee
- **p)** myringotomy
- **q)** pacemaker implantation
- **r)** prostatectomy, suprapubic or transurethra resection - removal of all or part of prostrate
- **s)** septectomy with rhinoplasty - removal of an obstruction of the nose (includes submucous resection; not covered for cosmetic purposes)
- **t)** tonsillectomy - removal of the tonsils
- **u)** tympanoplasty
- **v)** tympanotomy

CALLOUT: A second opinion is never required for emergency surgery. You will not be required to get a second opinion if any of the listed elective procedures are performed in urgent or emergency situations during the course of hospitalization, regardless of your diagnosis upon admission.

13. The Plan will pay for the second opinion consultation provided by a second opinion cooperating physician (a physician who has a written agreement with the Plan to participate in the second opinion program) when the opinion is arranged through Horizon BCBSNJ. Payment will also be made for any necessary diagnostic services, such as X-rays, electrocardiograms and laboratory tests. If the first two opinions conflict, the Plan will pay for an optional third opinion consultation arranged through Horizon BCBSNJ. However, the third opinion is not mandatory.

14. A second opinion cooperating physician accepts this program's payment as payment in full for the consultation. The cooperating physician agrees not to perform surgery or to treat you for the condition requiring referral. The second opinion or third opinion physician will not contact your physician to discuss any aspect of your case without your permission.

15. If you get a second (or third) opinion through Horizon BCBSNJ and then elect to have the procedure performed, regular Plan benefits are payable regardless of the second opinion consultant's recommendation. When types of elective surgery other than the categories specified on the prior page are recommended, you may still request a second opinion, but you are not subject to reduced benefits if you do not choose to have a second opinion.

16. Second opinions are not covered for the following:

a) surgery while the patient is already hospitalized
b) cosmetic surgery
c) dental surgery
d) emergency surgery
e) sterilization

17. How to get a second opinion. To arrange for a second opinion in New Jersey, call Horizon BCBSNJ toll-free at 1-800-355-2583. You will be given the names of three board-certified specialists who are cooperating physicians in the second opinion program in the appropriate specialty near you. You may consult any one of the three, or another of your own choice (as long as the physician cooperates in the program). After you've made an appointment with the consulting physician, call Horizon BCBSNJ again toll-free at 1-800-355-2583. Tell the nurse reviewer the name of the consulting physician and the date and time of your appointment. All necessary information and forms will be sent directly to the consulting physician.

CALLOUT: Elective surgery must ordinarily require at least an overnight stay in a hospital or the equivalent (same-day surgery in an ambulatory surgical center, for example). If you are not sure the procedure recommended for surgery is one that is listed, please call Horizon BCBSNJ for confirmation.

D. Case Management

1. Horizon BCBSNJ's Case Management staff can help you and your family explore all your options and make the right treatment choices when you're facing a chronic or catastrophic illness or injury. Case Management is designed for situations where treatment is complex and may last a long time, such as the following:

a) head injury requiring an inpatient stay
b) spinal cord injury
c) severe burn over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal illness, with a prognosis of death within six months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) substance abuse
l) mental or nervous conditions and psychoneurotic disorders
m) any other illness or injury determined by Horizon BCBSNJ to be catastrophic

2. A Case Manager coordinates everyone involved in treatment – the patient, the provider(s) and the Fund – to make sure that the treatment, level of care and facility are appropriate for your needs.

3. Case Management is evaluated and provided on a case by case basis. In some situations, Horizon BCBSNJ's staff will get it started by reviewing a patient's health status and the attending doctor's plan of care. They may determine that a level of benefits not necessarily provided by the Direct Access Plan is desirable, appropriate and cost-effective, so they may help you arrange for that care. If you would like Case Management assistance following an illness or surgery, call 1-800-355-2583.

CALLOUT: You are not required, in any way, to accept an alternate treatment/individual case management plan recommended by Horizon BCBSNJ.

V. ELIGIBLE MEDICAL EXPENSES AT A GLANCE

1. These are some of the most common expenses that are eligible for reimbursement under the Plan. If you have a question about whether the Plan covers a particular expense that's not on this list, contact Horizon BCBSNJ or the Fund Office.

PROVISION	HOW IT WORKS	
	IN-NETWORK	**OUT-OF-NETWORK**
How You Access Care	Go to any Network provider.	Go to any licensed/certified provider.
Basis for Reimbursement	All In-Network reimbursements are based on the allowance for medically necessary eligible expenses and subject to utilization management where required.	All Out-of-Network reimbursements are based on the allowance for medically necessary eligible expenses and subject to the annual deductible and to utilization management where required.
Annual Deductible	**Basic Expenses: N/A**	**For OON Basic Expenses and/or Supplemental Expenses**
	Supplemental Expenses	
– Individual	$500	$500
– Family	$1,000	$1,000
Co-payment (where applicable)	$25 Office Visit $30 Specialist Visit	N/A
Co-Insurance (where applicable): — Basic expenses	Plan pays 90% (For services that do not require copayment)	Plan pays 70% (Facility or Physician Charges) after the deductible
— Supplemental Expenses	Plan pays 80% after the deductible	Plan pays 70% after the deductible
Lifetime Maximum Benefit	N/A	N/A
Out of Pocket Maximum	$500 per person per year	N/A

ELIGIBLE BASIC SERVICES AND SUPPLIES		
EXPENSE	**WHAT YOU PAY**	
	IN-NETWORK	**OUT-OF-NETWORK**
Allergy testing and treatment (co-payment waived if testing is done only)	$30 co-payment	Deductible and 30% coinsurance
Ambulatory Surgery	10% coinsurance	Deductible and 30% coinsurance
Anesthesia	10% coinsurance	Deductible and 30% coinsurance
Assisted reproductive technology expenses (pre-authorization required)	$30 co-payment	Deductible and 30% coinsurance
	Benefits are payable up to a $5,000 lifetime maximum benefit combined with prescription benefits.	
Dental care and treatment (Refer to page 56 for covered treatment)	$0	Deductible and 30% coinsurance
Diagnostic x-ray and lab tests: — inpatient — outpatient/out-of-hospital	10% coinsurance	Deductible and 30% coinsurance
Dialysis center services	10% coinsurance	Deductible and 30% coinsurance
Emergency room care	$100 co-payment (waived if admitted)	
Facility (Hospital) expenses (utili zation management required)	10% coinsurance	Deductible and 30% coinsurance
Home health agency care	10% coinsurance	Deductible and 30% coinsurance
	Benefits are payable for up to 90 visits a year	

Inpatient physician services	10% coinsurance	Deductible and 30% coinsurance
Maternity/obstetrical care	$30 co-payment for the initial visit	Deductible and 30% coinsurance
Physical rehabilitation (inpatient)	10% coinsurance	Deductible and 30% coinsurance
Practitioner's charges for non-surgical care and treatment	$30 co-payment	Deductible and 30% coinsurance
Practitioner's charges for surgery	10% coinsurance	Deductible and 30% coinsurance
Pre-admission testing	$30 co-payment	Deductible and 30% coinsurance
Second opinion charges	$30 co-payment	Deductible and 30% coinsurance
Skilled nursing facility charges (following 3+ hospital days)	10% coinsurance	Deductible and 30% coinsurance
	Benefits are payable for up to 120 days a year.	
Surgical services	10% coinsurance	Deductible and 30% coinsurance
Therapeutic manipulations (chiropractor's charges)	$30 co-payment	Deductible and 30% coinsurance
	Benefits are payable for up to 30 visits a year.	
TMJ Syndrome Treatment	$30 co-payment	Deductible and 30% coinsurance

PREVENTIVE CARE		
EXPENSE	**WHAT YOU PAY**	
	IN-NETWORK	**OUT-OF-NETWORK**
Gynecological care and examinations (one routine per year)	$30 co-payment	Deductible and 30% co-insurance
Mammography (one per year for women over 40)	10% coinsurance	Deductible and 30% co-insurance
Pap smears (one routine per year)	10% coinsurance	Deductible and 30% co-insurance
Routine physical exams (age 19 and older, one per year)	$25 co-payment	Deductible and 30% co-insurance
Well-child care and immunizations (up to age 19)	$25 co-payment	Deductible and 30% co-insurance.
Prostate Cancer Screening (PSA Test)(one routine per year over the age of 40)	10% coinsurance	Not covered
THERAPY SERVICES		
Chelation therapy	10% coinsurance	Deductible and 30% coinsurance
Chemotherapy	10% coinsurance	Deductible and 30% coinsurance
Cognitive rehabilitation therapy	$30 co-payment	Deductible and 30% coinsurance
	Benefits are payable for up to 30 visits a year.	
Dialysis treatment	10% coinsurance	Deductible and 30% coinsurance
Infusion therapy	10% coinsurance	Deductible and 30% coinsurance

Occupational therapy	$30 co-payment	Deductible and 30% coinsurance
	Benefits are payable for up to 30 visits a year.	
Physical therapy (out-patient)	$30 co-payment	Deductible and 30% coinsurance
	Benefits are payable for up to 30 visits a year.	
Radiation treatment	10% coinsurance	Deductible and 30% coinsurance
Respiration therapy	10% coinsurance	Deductible and 30% coinsurance
Speech therapy	$30 co-payment	Deductible and 30% coinsurance
	Benefits are payable for up to 30 visits a year.	
Transplant services	10% coinsurance	Deductible and 30% coinsurance

ELIGIBLE SUPPLEMENTAL SERVICES AND SUPPLIES		
EXPENSE	**WHAT YOU PAY**	
	IN-NETWORK	**OUT-OF-NETWORK**
Ambulance	Deductible and 20% coinsurance	Deductible and 30% coinsurance
Blood	Deductible and 20% coinsurance	Deductible and 30% coinsurance
Durable Medical Equipment	Deductible and 20% coinsurance	Deductible and 30% coinsurance
	Prior Authorization required for purchases over $500.00	
Foot orthotics	Reimbursement limited to $750 a year (in combination with Podiatric Services)	
Home Infusion Therapy	Deductible and 20% coinsurance	Deductible and 30% coinsurance
Oxygen and its administration	Deductible and 20% coinsurance	Deductible and 30% coinsurance
Private Duty Nursing (for out-patient care)	Deductible and 20% coinsurance	Deductible and 30% coinsurance
	Benefits are payable for up to 240 hours a year	
Prosthetic devices	Deductible and 20% coinsurance	Deductible and 30% coinsurance
Wigs (For Hair loss due to radiation therapy, chemotherapy or second degree burns)	Deductible and 20% coinsurance	Deductible and 30% coinsurance
	Subject to a $500.00 benefit period max	

VI. ELIGIBLE BASIC SERVICES AND SUPPLIES

1. Expenses for Basic Services and Supplies are generally covered in full if you go In-Network for them (a $25 co-payment applies for general office visits; $30 for specialists). If you go Out-of-Network, the Plan pays 70% of the Plan allowance after you satisfy the annual deductible.

A. Allergy Testing and Treatment

1. The Plan covers allergy testing and treatment, including routine allergy injections. However, allergy testing and treatment are not covered if they are required for employment or for travel.

B. Ambulatory Surgery

1. The Plan covers charges for ambulatory surgery performed in a hospital outpatient department or out-of-hospital, a practitioner's office or an ambulatory surgical center in connection with covered surgery.

C. Anesthesia

1. The Plan covers anesthetics and their administration.

D. Assisted Reproductive Technologies

1. The Plan covers the cost of artificial and surgical procedures designed to enhance fertility (such as artificial insemination), up to a $5,000 lifetime maximum benefit per person, in combination with prescription benefits. Please see page 44 for ineligible fertility treatments.

E. Birthing Centers

1. If you prefer to use a birthing center instead of a hospital, the Plan covers its services – including pre-natal, delivery and post-natal care – as long as delivery takes place. If complications occur during labor, delivery may take place in a hospital because of the need for emergency and/or inpatient care. Delivery must occur within 24 hours of the transfer from the birthing center. If the patient is transferred to a hospital maternity program while receiving pre-natal care, any expenses for pre-natal care incurred at the center will be the responsibility of the patient. If, for any reason, the pregnancy does not go to term, the Plan will not provide payment to the birthing center.

F. Dental Care and Treatment

1. The medical benefits part of the Plan covers only the following dental care:

- **a)** diagnosis and treatment of oral tumors and cysts
- **b)** treatment of an accidental injury to natural teeth or the jaw, but only if the accidental injury occurs while the patient is covered under the Plan and the accidental injury is not caused, directly or indirectly, by biting or chewing. Treatment includes replacing natural teeth lost; in no event does it include orthodontic treatment.

2. To find out how the Plan covers other dental services and supplies, refer to the ***Dental Benefits*** schedule beginning on page 57.

G. Diagnostic X-ray and Laboratory Tests

1. The Plan covers charges for diagnostic x-rays and laboratory tests.

H. Emergency Care

1. The Plan covers charges relating to a medical emergency, including services provided by a hospital emergency room and diagnostic x-ray and laboratory charges. Coverage for emergency and urgent care includes coverage of trauma at any designated level I or II trauma center as medically necessary and appropriate, which shall be continued at least until, in the judgment of the attending physician, the patient is medically stable, no longer requires critical care and can be safely transferred to another facility. The Plan provides coverage for a medical screening examination provided upon a patient's arrival in a hospital, as required to be performed by the hospital in accordance with federal law, but only as necessary to determine whether a medical emergency condition exists.

CALLOUT: In the event of a potentially life-threatening condition, call 911.

I. Facility/Hospital Care

1. The Plan covers all necessary facility charges, including the following: hospital inpatient: semi-private room and board, routine nursing care and

- **a)** special care units
- **b)** hospital outpatient: services provided by a hospital outpatient clinic
- **c)** emergency room treatment if a covered person is an inpatient in a facility

J. Home Health Agency Care

1. The Plan covers home health care services, as long as your practitioner certifies that home health care is medically necessary and approves a written treatment plan. Your practitioner must establish the home health care plan in writing within 14 days after home health care starts and review the plan at least once every 60 days. No prior inpatient admission is required. One home health care visit is considered the same as four hours of care. Home health care services include:

- **a)** part-time nursing care by an RN or LPN (full-time or 24-hour service is covered when needed on a short-term basis)
- **b)** part-time home health aide services
- **c)** restorative physical, occupational or speech therapy
- **d)** medications, medical equipment and medical supplies prescribed by a doctor
- **e)** laboratory tests

2. Benefits for home health care are payable for up to 90 visits a year.

K. Inpatient Physician Services

1. The Plan covers a physician's charges for visits while you are an inpatient in a facility.

L. Mastectomies

1. The Plan covers a hospital stay of at least 72 hours following a modified radical mastectomy and a hospital stay of at least 48 hours following a simple mastectomy, unless the patient — in consultation with her physician — determines that a shorter length of stay is medically appropriate. While there is no requirement that the patient's provider obtain pre-approval from the Plan for prescribing 72 or 48 hours, as appropriate, of inpatient care, any notification requirements under the Plan remain.

CALLOUT: Under the Women's Health and Cancer Rights Act of 1998, participants who receive medical and surgical benefits in connection with a mastectomy, and who elect breast reconstruction in connection with such mastectomy, will be provided with coverage in a manner determined in consultation with the patient and attending physician for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. This applies to both In and Out-of-Network services.

M. Maternity/Obstetrical Care

1. The Plan covers services and supplies for pregnancy, childbirth, abortion or miscarriage. Obstetrical care is covered up to 48 hours after a normal vaginal birth and up to 96 hours after birth by cesarean section. Services and supplies provided by a hospital to a newborn child during the initial covered hospital stay of the mother and child are covered as part of the obstetrical care benefits. However, if the child's care is given by a different physician from the one who provided the mother's obstetrical care, the child's care will be covered separately.

2. The Plan also covers birthing center charges made by a practitioner for pre-natal care, delivery, and post-partum care in connection with a covered person's pregnancy.

CALLOUT: Under Federal law, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not under Federal law require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

3. Maternity/obstetrical care for child dependents. A dependent female child will receive benefits for routine obstetrical care. However such, benefits are not payable for the child of the dependent female child (that is, the grandchild).

N. Physical Rehabilitation

1. The Plan covers inpatient physical rehabilitation treatment in a rehabilitation center. Outpatient treatment will include the same services and supplies available to a facility inpatient. The services and supplies must be available in the rehabilitation center.

O. Practitioners/Physicians

1. The Plan covers the services of a physician or other medical practitioner for the medically necessary and appropriate care and treatment of an illness, or accidental injury.

P. Pre-Admission Testing

1. The Plan covers pre-admission diagnostic x-ray and laboratory tests needed for a planned hospital admission or surgery, as long as the tests are done on an outpatient or out-of-hospital basis within seven days before admission. However, the Plan does not cover tests that are repeated after admission or before surgery, unless the admission or surgery is deferred due to a change in the patient's health.

Q. Preventive Care

1. The Plan covers preventive care, including related diagnostic x-rays, laboratory tests and immunizations. Benefits for well-child care are payable through the end of the day before the child's 19th birthday.

R. Second Surgical Opinions

1. The Plan covers practitioner's charges for a second opinion and charges for related diagnostic x-rays and laboratory tests in accordance with utilization review. The Plan covers these charges if the practitioner who gives the opinion is board certified and qualified, by reason of his specialty, to give an opinion on the proposed surgery or hospital admission, is not a business associate of the practitioner who recommended the surgery and does not perform or assist in the surgery if it is needed.

S. Skilled Nursing Facilities

1. The Plan covers bed and board (including diets, drugs, medicines and dressings) and general nursing service in a skilled nursing facility. The patient must be admitted to the s killed nursing facility within 14 days of discharge from a hospital, following an inpatient stay of at least three days, for continuing medical care and treatment prescribed by a practitioner. Benefits are payable for up to 120 days of care a year.

T. Surgery

1. The Plan covers surgical procedures, subject to the following:

- **a)** The Plan will not make separate payment for pre-and post-operative services.
- **b)** If more than one surgical procedure is performed during the same operation through a single incision (or other route of access), the Plan will cover the primary procedure only. There will be no payment for any other procedures performed at the same time.

c) If more than one surgical procedure is performed during the same operation through more than one incision (or other route of access), the Plan will cover the primary procedure plus 50% of what the Plan would have paid for each of the other procedures had those procedures been performed alone.

U. Therapeutic Manipulations

1. The Plan covers charges for therapeutic manipulations (such as those you may receive from a chiropractor). Benefits are payable for up to 30 visits a year.

V. TMJ Syndrome Treatment

1. The Plan covers charges for treatment for Temporomandibular Joint Syndrome.

W. Therapy Services

1. The Plan covers charges for therapy services, as specified in the chart on page 32.

X. Transplants

1. The Plan covers pre-approved services and supplies for the following types of organ and tissue transplants:

a) cornea
b) kidney
c) lung
d) liver
e) heart
f) pancreas
g) allogeneic bone marrow
h) bone marrow (the plan provides benefits for the treatment of cancer by dose-intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants when performed by institutions approved by the National Cancer Institute or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists)
i) heart-valve
j) heart-lung

CALLOUT: Transplant benefits include surgical, storage and transportation services which are directly related to the donation of the organ and billed for by the hospital. The facility where you are being admitted must pre-certify any transplant procedure.

Y. Urgent Care

1. The Plan covers urgent care, which is care for a condition that is not life threatening, but should be treated by a provider within 24 hours.

VII. ELIGIBLE SUPPLEMENTAL SERVICES AND SUPPLIES

1. Expenses for Supplemental Services and Supplies are generally covered at 80% of the Plan allowance after you satisfy the annual deductible when you go in-network and 70% when you go out-of-network.

A. Ambulance Services

1. The Plan covers professional ground ambulance services for emergencies only to take you to the nearest local hospital (or, if your local hospital cannot provide you with the care you need, to the nearest hospital you can get needed care and treatment). The Plan covers ambulance services to another inpatient facility when medically necessary.

B. Blood

1. Blood, blood products, blood transfusions and the cost of testing and processing blood are covered. The Plan does not pay for blood which has been donated or replaced on behalf of the covered person.

2. Blood transfusions including the cost of blood, blood plasma and blood plasma expanders are covered from the first pint and only to the extent that the first pint and any additional pints to follow are not donated or replaced without charge through a blood bank or otherwise.

3. The Plan covers expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia for expenses incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia when the home treatment program is under the supervision of a state-approved hemophilia treatment center. Participation in a home treatment program shall not preclude further or additional treatment or care at any eligible facility if the number of home treatments does not exceed the total number of benefit days provided for any other illness under the Plan. “Blood products” include Factor VIII, Factor IX and cryoprecipitate; and “blood infusion equipment” includes syringes and needles.

C. Durable Medical Equipment

1. The Plan covers the purchase or rental of Durable Medical Equipment (DME) and supplies needed for therapeutic use. Prior Authorization is required for DME purchases over $500.00. The Plan will cover the cost of buying the equipment when the purchase price is expected to be less costly than long-term rental, or when the item is not available on a rental basis.

D. Home Infusion Therapy

1. The following home infusion therapy services and supplies are covered:

- **a)** solutions and pharmaceutical additives
- **b)** pharmacy compounding and dispensing services
- **c)** ancillary medical supplies
- **d)** nursing services associated with patient and/or alternative caregiver training, visits necessary to monitor intravenous therapy regimen and medical emergency care, but not for administration of home infusion therapy.

2. Home infusion therapy includes chemotherapy, intravenous antibiotic therapy, total parenteral nutrition, enteral nutrition (when sole source of nutrition), hydration therapy, intravenous pain management, gammaglobulin infusion therapy (IVIG), and prolastin therapy. **Home infusion therapy must be pre-certified.**

E. Foot Orthotics

1. The Plan covers foot orthotics under the Supplemental Services and Supplies Benefits. Reimbursement limited to $750.00 a year (in combination with Podiatric Services).

F. Oxygen

1. The Plan covers oxygen and its administration.

G. Private Duty Nursing Care

1. The Plan covers the charges of a registered nurse for private duty nursing care when ordered by a physician. Inpatient services are available if the Plan determines that the services provided are of such a nature or degree of complexity or quantity that they could not be or are not usually provided by the regular nursing staff of the facility. Services are available in the patient's home if the services provided require the skills of a nurse. For in our out-of-network out-patient care, benefits are payable for up to 240 hours a year.

H. Prosthetic Devices

1. The Plan covers the fitting and purchase of artificial limbs and eyes, and other prosthetic devices. To be covered, a device must take the place of a natural part of a covered person's body, or be needed due to a functional birth defect of an enrolled child, or as needed for reconstructive breast surgery. Wigs (for hair loss due to radiation or chemotherapy or second degree burns) are covered, subject to a $500.00 benefit period max.

VII. INELIGIBLE MEDICAL EXPENSES

1. These expenses are excluded and/or limited under the Plan.

a) acupuncture
b) non-emergency ambulance service, chartered air flights or other travel or communication expenses of patients, practitioners, nurses or family members
c) anesthesia and consultation services when given in connection with a non-covered service
d) inpatient admissions primarily for physical therapy and/or rehabilitation therapy
e) any charge beyond the allowance
f) any therapy that is not a covered therapy
g) balances for services after the Plan makes payments for the services
h) blood, blood plasma or other blood derivatives or components that you replace
i) broken appointments
j) charges incurred during a covered person's temporary absence from a provider's grounds before discharge
k) completion of claim forms
l) conditions classified as V-codes (conditions not arising from a mental disorder recognized in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association)
m) conditions related to behavior problems or learning disabilities
n) conditions the Plan determines are due to developmental disorders including mental retardation, academic skills disorders, or motor skills disorders (except as may be necessary to provide newly born dependents with coverage for accidental injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities)
o) conditions that, as determined by the Plan, lack a recognizable III-R classification in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (including, but not limited to, treatment for adult children of alcoholic families or co-dependency)
p) contraceptive drugs, even if prescribed for other than contraceptive purposes, and contraceptive devices including condoms, diaphragms, Norplant, jellies, ointments, or foams, or services to prescribe and fit contraceptive devices
q) co-payments, deductibles and the individual's part of any co-insurance
r) Expenses that exceed Plan maximums

- **s)** cosmetic services, including cosmetic surgery, procedures, treatment, drugs or biological products, unless required as a result of an accidental injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; or drugs prescribed for cosmetic purposes
- **t)** court-ordered treatment which is not medically necessary
- **u)** custodial care or domiciliary care, including respite care
- **v)** dental care or treatment, including appliances, except as specified on page 36 (also see "Dental Benefits," page 56, to find out how dental expenses may be covered)
- **w)** diversional/recreational therapy or activity
- **x)** drugs dispensed to a covered person while a patient in a facility
- **y)** drugs, obtained from a state or local public health agency, for the treatment of venereal disease or mental disease
- **z)** drugs dispensed by other than a pharmacist or a pharmacy or for services rendered by a pharmacist which are beyond the scope of their license, or drugs given by a physician or other practitioner.
- **aa)** education or training while a covered person is confined in an institution that is primarily an institution for learning or training
- **bb)** employment/career counseling
- **cc)** experimental or investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices
- **dd)** eye examinations, eyeglasses, contact lenses, and all fittings (however, see "Vision Care Benefits," page 72, to find out how these expenses may be covered)
- **ee)** surgical treatment for the correction of a refractive error including, but not limited to, radial keratotomy (however, see "Vision Care Benefits," page 72, to find out how these expenses may be covered)
- **ff)** facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a provider that is not an eligible facility
- **gg)** fertility enhancement treatment other than artificial insemination, including, but not limited to, in-vitro fertilization, in-vivo fertilization, gamete-intrafallopian-transfer (GIFT), Zygote Intra-fallopian Transfer (ZIFT), sperm, egg, and/or inseminated eggs procurement and processing and freezing, and storage and thawing of sperm and/or embryos
- **hh)** hearing aids or fitting of hearing aids (however, see "Hearing Aid Benefits," page 73, to find out how these expenses may be covered)
- **ii)** herbal medicine

jj) home health care visits for care of mental, psychoneurotic or personality disorders, or in connection with administration of dialysis

kk) housekeeping services except as an incidental part of the eligible services of a home health care agency

ll) hypnotism

mm) illness or accidental injury which occurred on the job or which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law

nn) illnesses, mental or nervous conditions or substance abuse, including conditions which are the result of disease or bodily infirmity, which are covered or could have been covered for benefits provided under workers' compensation, employer's liability or similar law; or illnesses or injuries occurring while the individual is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit or intended for wage or profit

oo) immunizations, except as specified on page 39

pp) local anesthesia charges billed separately by a practitioner for surgery performed on an outpatient basis

qq) maintenance therapy for physical therapy, manipulative therapy, occupational therapy or speech therapy

rr) marriage, career or financial counseling

ss) sex therapy

tt) medical emergency services or supplies, when not rendered by a practitioner

uu) membership costs for health clubs, weight loss clinics and similar programs

vv) methadone maintenance

ww) milieu therapy

xx) non-medical equipment which may be used primarily for personal hygiene or for comfort or convenience of a covered person rather than for a medical purpose, including air conditioners, dehumidifiers, purifiers, saunas, hot tubs, televisions, telephones, first aid kits, exercise equipment, heating pads and similar supplies

yy) nutritional counseling and related services

zz) pastoral counseling

aaa) personal comfort and convenience items

bbb) private duty nursing services of a nurse who ordinarily resides in your home or is a member of your immediate family

ccc) psychoanalysis to complete the requirements of an educational degree or residency program

ddd) psychological testing for educational purposes

eee) removal of abnormal skin outgrowths and other growths including paring or chemical treatments to remove corns, callouses, warts, hornified nails and all other growths, unless it involves cutting through all layers of the skin

fff) replacements or repairs of durable medical equipment or the rental or purchase of any items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not fully meet the definition of durable medical equipment

ggg) rest or convalescent cures

hhh) room and board charges for any period of time during which the covered person was not physically in the room

iii) routine examinations or health wellness, including related diagnostic x-rays and laboratory tests, except as specified on page 36

jjj) pre-marital or similar examinations or tests not required to diagnose or treat illness, accidental injury, mental illness or substance abuse

kkk) screening, research studies, education or experimentation, mandatory consultations required by hospital regulations, routine pre-operative consultations

lll) foot care, except as may be medically necessary and appropriate for the treatment of certain illness or accidental injury, including treatment for corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, symptomatic complaints of the feet

mmm) self-administered services such as biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training

nnn) services involving equipment or facilities used when the purchase, rental or construction has not been approved in compliance with applicable state laws or regulations

ooo) services performed by a hospital resident, intern or other practitioner who is paid by a facility or other source, who is not permitted to charge for services covered under the Plan, whether or not the practitioner is in training (hospital-employed specialists may bill separately for their services)

ppp) services performed by anyone who does not qualify as a physician

qqq) services provided during a stay at a facility which in whole or in part was for diagnostic studies (this exclusion applies when the services were provided for diagnosis, evaluation, confirmation, or to check the current status of a condition which was treated in the past)

rrr) services required by the group as a condition of employment or rendered through a medical department, clinic, or other similar service provided or maintained by the group

sss) services or supplies:

- eligible for payment under either federal or state programs (except Medicaid)
- for which a charge is not usually made or services at a public health fair
- for which the provider has not received a certificate of need or such other approvals as are required by law
- for which the covered person would not have been charged if they did not have health care coverage
- furnished by one of the following members of the covered person's family, unless otherwise stated in this booklet: spouse, child, parent, in-law, brother or sister
- in connection with any procedure or examination not necessary for the diagnosis or treatment of injury or sickness for which a legitimate diagnosis has been made because of existing symptoms
- needed because the covered person engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony
- not specifically covered by the Plan
- provided by a practitioner if the practitioner bills the covered person directly for the services or supplies, regardless of the existence of any financial or contractual arrangement between the practitioner and the provider
- provided by or in a Government hospital unless the services are for treatment of a non-service medical emergency, or by a Veterans' Administration Hospital of a non-service related illness or accidental injury; or the Hospital is located outside of the United States; or unless otherwise required by law (this limitation does not apply to military retirees, their dependents, and the dependents of active duty military personnel who have both military health coverage and coverage under the Plan, and receive care in facilities run by the Department of Defense or Veteran's Administration)
- provided by a licensed pastoral counselor in the course of his normal duties as a pastor or minister
- provided by a social worker, except as otherwise provided
- provided during any part of a stay at a facility, or during home health care chiefly for bed rest, rest cure, convalescence, custodial or sanatorium care, diet therapy or occupational therapy
- received as a result of war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection
- rendered prior to the covered person's effective date or after his termination date of coverage under the program, unless specified otherwise

- which are specifically limited or excluded elsewhere in this booklet
- which are not medically necessary and appropriate
- for which a covered person is not legally obligated to pay

ttt) skilled nursing facility services for care of mental or nervous or substance abuse

uuu) special medical reports not directly related to treatment of the covered person

vvv) speech therapy for the treatment of developmental anomalies

www) stand-by services required by a practitioner

xxx) services performed by surgical assistants not employed by a facility.

yyy) sterilization reversal

zzz) sunglasses even if by prescription

aaaa) sex change surgery, sex hormones, and related medical and psychiatric services to change sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders

bbbb) surrogate motherhood

cccc) telephone consultations

dddd) transplants, except as specified on page 40

eeee) transportation; travel

ffff) vision therapy, vision or visual acuity training, orthoptics and pleoptics

gggg) vitamins and dietary supplements, except prenatal and children's vitamins requiring a prescription

hhhh) weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products

iiii) wigs, toupees, hair transplants, hair weaving, or any drug used to eliminate baldness unless deemed medically necessary

jjjj) all services rendered outside of the United States are not covered

IX. MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

1. This part of the Plan is administered by Managed Health Network (MHN), an independent organization that provides behavioral health care substance abuse services. You must use a participating MHN network provider to get benefits. If you use an Out-of-Network facility or provider you will responsible for the $500 individual, $1,000 family annual out-of-network deductible, which is combined with your medical out-of-network annual deductible.

A. In-Patient Treatment

1. If you need a hospital stay or other inpatient care, you must pre-certify it (see "How to Pre-certify," below). As long as the service is medically necessary, you go to an in-network facility and the stay has been pre-certified, the Plan pays 90% of the contracted amount, which is combined with your annual medical out of pocket co-insurance maximum for inpatient mental health or substance abuse treatment, including partial hospitalization and day programs. If you use an Out-of-Network facility and/or don't pre-certify care, no benefits are payable (unless it's an emergency, as described, below).

2. What to do in an emergency. In a mental health emergency, the patient should first go to the nearest emergency room, then call MHN (a provider or relative may make the call for the patient). As long as MHN is contacted within 24 hours of admission, the Plan will pay benefits for charges that are determined to be emergency care charges. Benefits are payable until the patient is stabilized, up to a maximum of four days in an Out-of-Network facility. If the facility is not part of the MHN provider network, the patient may be transferred to a network facility once the emergency has passed.

B. How to Pre-Certify

1. To pre-certify in-patient care, call MHN toll-free at 1-800-327-6517. If you can't make the call yourself, your MHN network provider, treatment facility or a family member can call instead. As part of the pre-certification process, your MHN case manager will determine eligibility and help make arrangements for required admissions, transportation to and from facilities, and ongoing case management during and after hospitalization.

C. Out-Patient Treatment

1. For outpatient mental health or substance abuse treatment from a network provider, the Plan pays the full contracted cost of the initial consultation and the full contracted cost of each subsequent visit. Outpatient treatment may include any or a combination of different approaches to treatment, such as individual and group psychotherapy, couples and family treatment, psychiatric and medication evaluations, and ongoing medication management, depending on the patient's needs.

- **a) Psychological testing.** Psychological testing is covered as long as it's clinically indicated. Psychological testing for educational purposes is not covered.
- **b) Electroconvulsive therapy.** Electroconvulsive therapy (ECT) is covered on both an inpatient and outpatient basis, as long as it's pre-certified and provided by a network provider.

D. Confidentiality

1. MHN is committed to protecting your privacy, and all contact with them is strictly confidential as required by federal and state laws. If anyone else requests information, MHN must first get your approval before they can release it. All services are kept confidential in accordance with federal, state and local laws and professional standards of confidentiality. Among the situations where the provider is required by law to notify authorities are instances of child abuse, elder abuse or a professional determination that the patient is a threat to personal safety.

E. What's Not Covered

1. The mental health and substance abuse treatment part of the Plan does not cover any of the following:

- **a)** long-term hospitalization for residential or chronic care
- **b)** treatment of detoxification in newborns
- **c)** treatment of congenital and/or organic disorders (this includes, without limitation, Alzheimer's disease, mental retardation (other than the initial diagnosis), organic brain disease, delirium, dementia, amnesic disorders and other cognitive disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders)
- **d)** treatment for chronic pain and other pain disorders, smoking cessation, nicotine dependence, nicotine withdrawal and nicotine-related disorders
- **e)** treatment of obesity and eating disorders – other than the diagnosis of anorexia and bulimia nervosa as defined in the Diagnostic and Statistical Manual of Mental Disorders – unless otherwise required by law
- **f)** court-ordered testing and treatment
- **g)** private hospital rooms and/or private duty nursing, unless medically necessary and authorized by MHN
- **h)** ancillary services such as:
  - vocational rehabilitation
  - behavioral training
  - speech or occupational therapy
  - sleep therapy and employment counseling
  - training or educational therapy for reading or learning disabilities
  - other education services

i) testing, screening or treatment for:

- learning disorders, expressive language disorders, mathematics disorder, phonological disorder and communication disorder NOS
- motor skills disorders and development coordination disorder
- all disorders of infancy and early childhood and development disorders including, but not limited to, communication disorders, pervasive developmental disorders, autistic disorder, Rett's disorder, Asperger's disorder (except as otherwise required by law)
- disorders resulting from general medical conditions, including but not limited to catatonic disorder due to general medical condition, personality change due to general medical disorder, narcolepsy, stuttering, stereotypic movement disorders, sleep disorders, tic disorders, elimination disorder, sexual dysfunctions, primary insomnia
- personality disorders
- pedophilia
- primary sleep disorders, primary hypersomnia, and dyssomnia NOS
- age-related cognitive decline

j) treatment of conditions that are medical in nature, even when such conditions may have been caused by a mental disorder

k) treatment by providers other than those within licensing categories then recognized by MHN as providing medically necessary services in accordance with applicable medical community standards

l) treatment rendered for conditions not listed as an Axis I disorder (V Code diagnosis listed as an Axis I disorder are also excluded unless otherwise specified in the Plan)

m) services beyond what's authorized by MHN

n) psychological testing except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer based reports

o) all prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a provider in connection with inpatient treatment (these may be covered under other parts of the Plan)

p) inpatient services, treatment, or supplies rendered in a non-emergency by a non-participating provider, unless authorized by MHN or the Plan

q) damage to a hospital or facility caused by the participant

r) healthcare services, treatment or supplies determined to be experimental by MHN in accordance with accepted mental health standards, except as otherwise required by law

s) healthcare services, treatment or supplies:
- provided as a result of any Workers' Compensation law or similar legislation
- obtained through, or required by, any governmental agency or program
- caused by the conduct or omission of a third party for which the participant has a claim for damages or relief

t) healthcare services, treatment, or supplies for military service disabilities for which treatment is reasonably available under governmental healthcare programs

u) treatment for biofeedback, acupuncture or hypnotherapy

v) healthcare services, treatment or supplies rendered to the participant which are not medically necessary services (this includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, custodial or domiciliary care as determined by MHN)

w) services received before the participant's effective date, during an inpatient stay that began before the participant's effective date or received after the participant's coverage ended, except as specifically stated herein

x) services for which:
- the person is not legally obligated to pay
- no charge is made to the person
- no charge is made to the person in the absence of insurance coverage
- it is provided without cost to the person by a local, state or federal government agency

y) services in connection with conditions caused by an act of war

z) conditions caused by release of nuclear energy, whether or not the result of war

aa) emergency room services not provided by a psychiatrist directly related to the treatment of a mental disorder in accordance with the limitations listed above

bb) professional services received from a person who lives in the participant's home or who is related to the participant by blood or marriage

cc) any services or supplies to the extent they are covered under Parts A or B of Medicare if the participant is either enrolled in Part A of Medicare (whether or not the participant is enrolled in Part B of Medicare) or is entitled to enroll in Medicare and has made the required number of quarterly contributions to the Social Security System (whether or not the participant has actually enrolled in Medicare or claimed Medicare benefits)

dd) services performed in any emergency room which are not directly related to the treatment of a mental disorder

ee) all other services, confinements, treatments or supplies not provided primarily for the treatment of the specific conditions described in this booklet and/or specifically included as covered services elsewhere in this Plan

ff) marital counseling

X. PRESCRIPTION DRUG BENEFITS

1. There are three ways to get your prescriptions filled: at a local pharmacy, or through Benecard PBF's Mail Order and Specialty Programs.

A. At the Pharmacy

1. To get prescription drug benefits at a retail pharmacy, go to your local pharmacy to have your prescription filled and show your Benecard PBF prescription drug discount card. Most national chain and independently-owned drugstores accept the card. All prescriptions filled at a retail pharmacy provide you with up to a 30-day supply. You'll pay a 10% copayment with a minimum of $5 (generic)/$15 (formulary)/$30 (non-formulary) with a maximum of $75.

IF YOUR PRESCRIPTION COSTS	YOU PAY
Less than $50	$5
At least $50 but less than $750	10% of the cost of the prescription
$750 or more	up to $75

2. For example, if your generic prescription costs $35, your co-payment is $5. If your generic prescription costs $125, your co-payment is $12.50. See "Claims and Appeal Procedures," page 80, for information about how to claim benefits.

B. Through Mail Order

1. The Benecard PBF Mail Order Program is designed for those who take maintenance drugs (medication taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes and asthma). You'll pay 10% of your eligible prescription drug expenses, with a minimum of $10 (generic)/$30 (formulary)/$60 (non-formulary) and a $150 maximum payment per prescription, for up to a 90-day supply.

CALLOUT: If you have a chronic condition and you need to take the same medication for more than 30 days, you must use the Mail Order Program (although you may fill two 30 day supplies at the pharmacy).

2. Filling your prescription by mail. There are three ways to use the mail order program:

- **a)** Call Benecard PBF, mail order pharmacy at 1-888-907-0070.
- **b)** Visit the website: www.benecardpbf.com.
- **c)** Get a Mail Order Pharmacy Order Form/self-mailer from the Fund Office or Benecard PBF.

3. If you have any questions on the above or about your prescription, please call Benecard PBF Member Services toll free at 1-888-907-0070.

4. Refills are not shipped automatically. If you have remaining refills on your original prescription, request your mail order refill two weeks before you need it to avoid running out of medication. You should receive your refill within a week.

5. Prescriptions for medicines not available through the mail (such as narcotics) will be returned to you.

C. Through Specialty Medication Pharmacy

1. The Benecard PBF Specialty Pharmacy is designed for those members who currently utilize or will be utilizing self-injectable medications (excluding insulin), specialty medications, and oral medications for oncology or transplants. If you are currently utilizing these special medications or will be utilizing these medications in the near future, please contact Benecard PBF Specialty Pharmacy at 1-888-907-0070. Benecard PBF RX Specialty Pharmacy will send your medications directly to your home and will provide unlimited access to skilled specialty pharmaceutical consultation when and if you need it. Benecard PBF Specialty Pharmacy dispenses your medication every 30 days and charges a co-payment once every 30 days. Regular prescriptions can still be filled at your local pharmacy and maintenance prescriptions through Benecard PBF's Mail Order Program.

You'll pay 10% of your specialty prescription drug expenses with a minimum co-payment of $50 and a $100 maximum.

****Brand name prescriptions with a generic equivalent are covered but the member will be responsible for the differential charge (the difference between the brand name prescription price and the generic price) in addition to the required co-payment.**

D. Eligible Drugs

1. The following drugs are covered under the Plan:

- **a)** federal legend prescription drugs
- **b)** drugs requiring a prescription under the applicable state law
- **c)** insulin, insulin syringes and needles

- **d)** diabetic test strips
- **e)** Vitamins for infants to 12 months requiring a prescription
- **f)** pre-natal vitamins requiring a prescription
- **g)** drugs used for infertility treatment, up to the $5,000 maximum lifetime benefit for infertility treatment (in combination with medical infertility treatment).

E. Ineligible Drugs

1. The following drugs are not covered under the Plan:

- **a)** over-the-counter drugs and its equivalents (no matter the dosage) and vitamins
- **b)** drugs used in clinical trials or experimental studies
- **c)** birth control devices, except diaphragms
- **d)** drugs prescribed for cosmetic purposes
- **e)** drugs used for weight loss (unless you meet the Plan's medical criteria)
- **f)** therapeutic devices or appliances, support garments and other non-medical substances
- **g)** drugs intended for use in a physician's office or another setting other than home use
- **h)** prescriptions which an eligible person is entitled to receive without charge under any workers' compensation law, or any municipal, state, or federal program.
- **i)** blood glucose meters
- **j)** insulin injecting devices
- **k)** respiratory therapy supplies
- **l)** topical dental fluoride
- **m)** immunizations
- **n)** electrolyte replacement
- **o)** liquid nutritional supplemental
- **p)** infant formulas
- **q)** hair replacement supplies (gels, shampoos, ointments, etc.).

CALLOUT: Some prescriptions have a quantity limit and/or require a prior authorization. Please contact Benecard PBF for further assistance.

XI. DENTAL BENEFITS

1. The Plan's dental benefits are designed to promote good dental health by providing coverage for a broad range of dental services and supplies.

A. How Eligible Dental Expenses Are Defined

1. To be considered for reimbursement, a dental service must meet the following criteria:

- **a)** It must be provided or performed by a dentist (or, for some treatments such as teeth cleaning, by a licensed dental hygienist working under the dentist's supervision).
- **b)** It must be for necessary dental care that begins and ends while you are covered under the Plan.
- **c)** It has to be a covered charge.
- **d)** You or your dependent must be enrolled in the Plan at the time covered services are rendered.
- **e)** The service or supply must not be eligible for benefits under any other part of the Plan.
- **f)** X-ray maximum is $70.00 per year.
- **g)** Major dental work / expenses require pre-authorization, with x-rays attached (ie: root canals, post and core, crowns, partial dentures, surgical extractions, root planning (perio chart required), osseous surgery, implants, occlusals, Alveoplasty and Vestibululoplasty. Your dentist should mail a pre-determination to the Fund Office prior to commencing dental work.

B. About Your Dental Benefits

1. Your dental benefits are a fee-for-service arrangement. The Plan pays benefits according to a Schedule of Covered Dental Procedures, which starts below. If your dentist charges more than the scheduled amount, you are responsible for the difference. You may visit any dentist or specialist you wish; benefits are the same no matter who you use for your care.

CALLOUT: The Plan will pay the actual expense for a covered dental service up to the maximum allowable benefit for that procedure, as indicated in the Schedule of Covered Dental Procedures.

C. Schedule of Covered Dental Procedures

The schedule below shows the maximum amount the Plan pays for various dental services. If a procedure is not listed, it may not be covered.

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
CLINICAL ORAL EXAMINATIONS		
D0110	Initial Oral Examination (once every six months)	35
D0120	Periodic Oral Evaluation (once every six months)	25
D0140	Limited Oral Evaluation	20
RADIOGRAPHS		
D0210	Intraoral - complete series (including bitewings), one series in any 36 consecutive months (once every three years)	70
D0220	Intraoral - periapical, first film	10
D0230	Intraoral - periapical, each add. film	7
D0240	Intraoral - occlusal film, each	25
D0270	Bitewings - single film (maximum four in any six consecutive months) (Once every six months)	10
D0272	Bitewings - two films (Once every six months)	30
D0274	Bitewings - four films (Once every six months)	40
D0330	Panoramic film, one in any 36 consecutive months (Once every three years)	70
D0340	Cephalometric film	70
D0460	Pulp Vitality	20
D0470	Diagnostic Casts	25
D0471	Diagnostic Photographs	25

PREVENTIVE (Refilling of Same tooth covered once every six months, D2110-D2387) (Coverage once every five years, D2510-D2652)		
D1110	Prophylaxis – Adult (cleaning and scaling of teeth) (Once every six months)	60
D1120	Prophylaxis – Child (cleaning and scaling of teeth) (Once every six months)	40
D1203	Topical application of fluoride – excluding prophy – Child (Under age 15) (Once every six months)	20
D1351	Sealant – per tooth (For children under the age of 14, once every two years)	25
D1510	Space maintainer - fixed unilateral	200
D1515	Space maintainer - fixed bilateral	250
D2110	Amalgam – one surface primary	70
D2120	Amalgam – two surfaces primary	80
D2130	Amalgam – three surfaces primary	90
D2131	Amalgam – four or more surfaces primary	100
D2140	Amalgam – one surface, primary or permanent	80
D2150	Amalgam – two surfaces, primary or permanent	100
D2160	Amalgam – three surfaces, primary or permanent	110
D2161	Amalgam – four or more surfaces, primary or permanent	120
D2330	Resin - one surface anterior	90
D2331	Resin - two surfaces anterior	110
D2332	Resin - three surfaces anterior	130
D2335	Resin – three or more surfaces or inv. incisal angle anterior	140
D2336	Composite resin crown anterior – primary	100
D2380	Resin one surface posterior – primary	80

PREVENTIVE (Refilling of Same tooth covered once every six months, D2110-D2387) (Coverage once every five years, D2510-D2652)		
D2381	Resin – two surfaces posterior – primary	100
D2382	Resin – three surfaces posterior – primary	120
D2385	Resin – one surface posterior – permanent	90
D2386	Resin – two surfaces posterior – permanent	110
D2387	Resin – three surfaces posterior – permanent	130
D2510	Gold inlay – one surface	200
D2520	Inlay – metallic – two surfaces	350
D2530	Inlay – metallic – three or more surfaces	400
D2540	Onlay – metallic	425
D2620	Inlay – porcelain/ceramic – two surfaces	350
D2630	Inlay – porcelain/ceramic – three or more surfaces	375
D2640	Onlay – porcelain/ceramic – per tooth	400
D2650	Inlay composite – one surface	150

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
D2651	Inlay composite – two surfaces	200
D2652	Inlay/composite/resin – three or more surface laboratory	250
CROWNS (Covered once every five years, D2710 – D2810)		
D2710	Crown – resin laboratory	300
D2720	Crown – resin with high noble metal	350
D2740	Crown – porcelain/ceramic substrate	500
D2750	Crown – porcelain fused to predom base metal	500
D2751	Crown - porcelain fused to base metal	500
D2752	Crown - porcelain fused to noble metal	500
D2790	Crown – full cast high noble metal	500
D2791	Crown - full cast predom base metal	400
D2792	Crown – full cast noble metal	400
D2810	Crown – 3/4 cast metallic	375
OTHER RESTORATIVE SERVICES		
D2910	Recement inlay	30
D2920	Recement crown	30
D2930	Prefab stainless steel crown - primary tooth (once every five years)	125
D2931	Prefab stainless steel crown – permanent tooth (once every five years)	125
D2932	Prefab resin crown (once every five years)	125
D2940	Sedative fillings	30

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
OTHER RESTORATIVE SERVICES		
D2950	Buildup including any pins	100
D2951	Pin reten – per tooth in add rest	25
D2952	Cast post & core in addition to crown (once every five years)	150
D2954	Prefab post & core in addition to crown (once every five years)	125
D2962	Laminate porcelain/veneer (once every five years)	400
D2980	Crown repair – by report	100
D3110	Pulp cap direct excel final rest	25
D3120	Pulp cap indirect excel final rest	20
ENDODONTICS Root Canal Therapy (including treatment plan, clinical procedures and follow-up care)		
D3220	Therapeutic pulpotomy	75
D3310	Root canal therapy – anterior	400
D3320	Root canal therapy - bicuspid	500
D3330	Root canal therapy - molar	600
D3348	Retreat root canal - molar	600
D3351	Apexification	100
D3410	Apicoetomy/periradicular surg – ant	400
D3411	Apicoetomy additional root	50
D3421	Apicoetomy/periradicular surg – bicus first root	400

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
ENDODONTICS **Root Canal Therapy** **(including treatment plan, clinical procedures and follow-up care)**		
D3425	Apicoetomy/periradicular surg – molar first root	500
D3426	Apicoectomy/perirad surgery - each additional root	50
D3430	Retrograde filling - per root	50
D3431	Additional amalgam seal	50
D3450	Root amputation – per root (benefits payable for specialist only)	300
D3920	Hemisection including any root removal	300
D3960	Bleaching of discolored tooth	75
D4110	Periodontal exam	25
D4189	Replacement of a broken implant abutment	50

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
PERIODONTICS Surgical Services (including usual post-operative services)		
D4210	Gingivectomy or gingivoplasty – per quadrant	200
D4211	Gingivectomy or gingivoplasty – single site	50
D4220	Gingival curettage, surgical per quadrant	100
D4249	Crown lengthening – hard tissue	300
D4262	Bone replacement graft – multiple sites (incl. slap E)	100
D4263	Osseous graft/first site	100
D4266	Guided tissue regiment	300
D4267	Guided tissue regeneration	300
D4270	Pedicle soft tissue graft procedure	350
D4271	Free soft tissue graft donor site	400
D4273	Connective tissue graft for root curettage	350
D4274	Distal wedge surgery	100
D4320	Provisional splinting intracoronal	100
D4321	Provisional splinting extracoronal	100
D4381	Actsite – antibiotic injection (Covered 4-6 weeks after root planning, 2 sites per quadrant)	50

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
ADJUNCTIVE PERIODONTAL SERVICES		
D3290	Hemisection	100
D4341	Root planing, per quadrant (once a year)	100
D4910	Periodontal maintenance (twice a year)	50
REMOVABLE PROSTHODONTICS (Removable Dentures) (Covered once every five years D5110-D5281)		
D5110	Complete denture, upper	600
D5120	Complete denture, lower	600
D5130	Immediate denture, upper	700
D5140	Immediate denture, lower	700
D5211	Upper partial - acrylic base (including any conventional clasps and rests)	350
D5212	Lower partial - acrylic base (including any conventional clasps and rests)	350
D5213	Upper transitional partial denture - predominantly base metal with acrylic saddles (including any conventional clasps and rests)	700
D5214	Lower transitional partial denture - predominantly base metal with acrylic saddles (including any conventional clasps and rests)	700
D5281	Upper acrylic flexite denture	300

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
REPAIRS, ADJUSTMENTS AND OTHER REMOVABLE DENTURE MAINTENANCE PROCEDURES		
D5410	Adjust complete denture - upper	25
D5411	Adjust complete denture - lower	25
D5421	Adjust partial denture - upper	25
D5422	Adjust partial denture - lower	25
D5510	Repair of broken denture base	75
D5520	Repair missing/broken tooth-complete denture - each tooth	25
D5610	Repair resin denture base	75
D5620	Repair cast framework	75
D5630	Repair or replace broken clasp	75
D5640	Replace broken teeth, per tooth	25
D5650	Add tooth to partial denture	45
D5660	Add clasp to partial denture	50

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
REBASE AND RELINE PROCEDURES		
D5730	Reline complete upper denture, chairside	150
D5731	Reline complete lower denture, chairside	150
D5740	Reline upper partial denture, chairside	100
D5741	Reline lower partial denture, chairside	100
D5750	Reline complete upper denture, lab	250
D5751	Reline complete lower denture, lab	250
D5760	Reline upper partial denture, lab	150
D5761	Reline lower partial denture, lab	150
D5820	Interim partial denture, upper	150
D5821	Interim partial denture, lower	150
D5850	Tissue conditioning procedure	50
D5860	Overdenture (once every five years)	600
D5862	Precision attachment by report	150
D5982	Surgical guide stent	150
D6030	Endosseous implant – in the bone (once every five years)	800
D6080	Implant maintenance	30
FIXED BRIDGEWORK		
D6095	Repair implant	75
D6100	Implant removal	150
D6199	Implant component	100
D6210	Pontic – cast high noble metal (once every five years)	350

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
FIXED BRIDGEWORK (Continued)		
D6212	Pontic – cast noble metal (once every five years(	350
D6240	Pontic - porcelain fused to high noble metal (once every five years)	500
D6241	Pontic - porcelain fused to predom base metal (once every five years)	500
D6242	Pontic - porcelain fused to noble metal (once every five years)	500
D6250	Pontic – resin with high noble metal (once every five years)	500
D6545	Retainer – cast metal res bond fix prosthetic	200
D6640	Replace facing with acrylic	100
D6750	Crown - porcelain fused to high noble metal (once every five years)	500
D6751	Crown - porcelain fused to base metal (once every five years)	500
D6752	Crown - porcelain fused to noble metal (once every five years)	500
D6780	Crown – 3/4 gold (once every five years)	400
D6790	Crown – full cast high noble metal (once every five years)	500
D6792	Crown – full cast noble metal (once every five years)	500
D6930	Recement bridge	50

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
FIXED BRIDGEWORK (Continued)		
D6950	Precision attachment	150
D6970	Cast post & core in add (once every five years)	125
D6972	Prefab post & core in add. to bridge retainer (once every five years)	125
D6975	Coping	200
D6980	Fixed partial denture repair, by report	80
D6999	Removal of implant	150
ORAL SURGERY Extractions (includes local anesthesia and routine postoperative care)		
D7110	Oral surgery extract single tooth	100
D7120	Surgery extract – each additional tooth (performed on the same day)	50
D7130	Root removal – exposed roots	100
D7210	Surgical removal of erupted tooth	125
D7220	Removal of impacted tooth - soft tissue	225
D7230	Removal of impacted tooth - partially bony	250

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
ORAL SURGERY **Extractions (Continued)** **(includes local anesthesia and routine postoperative care)**		
D7240	Removal of impacted tooth - completely bony	275
D7250	Surgical removal resid, tooth roots - cutting procedure	150
D7280	Surgical abcess of an unerupted tooth - ortho	300
D7281	Surgical abcess of an unerupted tooth – aid erup	300

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
D7286	Biopsy of oral tissue - soft	300
D7310	Alveoplasty in conj/w extract - per quad	150
D7320	Alveoplasty no extract - per quad	300
D7350	Vestibululoplasty	300
D7430	Excision of lesion/cyst r&c	200
D7431	Excision of benign tumor lesion	250
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25cm	200
D7470	Exostosis r&c; maxillary rt; tuberosily reduct	150
D7510	Incision and Drainage Abcess - intraoral, soft tissue	50
D7880	Occlusal orthotic device – by report (once every three years)	400
D7910	Suture – 5cm	100
D7960	Frenulectomy - separate procedure	100
D7970	Excision of hyperplastic tissue - per arch	125
D7971	Excision of pericoronal gingival	75
D7999	Hydroxylapatite Filling	200
D9110	Palliative - emergency treatment dent. pain - minor pain	50
D9220	General anesthesia – first 30 minutes	100
D9221	General anesthesia – each additional 30 minutes	55
D9230	Analgesia	25

ADA Code	PROCEDURE	Maximum Reimbursement (Dollar Amount)
D9240	Intravenous sedation	100
D9248	Conscious sedation	50
D9310	Consultation (benefits payable for specialist only)	35
D9611	Antimicrobal irrigation	25
D9630	Other drugs and/or med by report/cutting bridge	25
D9640	Nightguard and braxism (once every three years)	100
D9910	Desensitizing	20
D9940	Occlusal guard, by report (once every three years)	150
D9950	Occlusion analysis - mounted case	50
D9951	Occlusal adjustment – limited (once every three years)	50
D9952	Occlusal adjustment – complete (once every three years)	100
D9999	Miscellaneous removal of splint	25
ORTHODONTICS (Once per lifetime per individual)		
D8110	Appliance	600
D8460	Monthly treatment	150 for 24 months

XII. VISION CARE BENEFITS

The Plan's Vision Care Benefits are designed to help you pay for regular eye exams and corrective lenses.

A. Eligible Vision Care Expenses

1. The Plan covers the following eligible vision care expenses:

- **a)** eye examinations performed by a legally qualified and licensed ophthalmologist or optometrist
- **b)** prescribed corrective lenses (either eyeglasses or contact lenses)
- **c)** laser vision correction (this benefit is available only to eligible participants (for the member and one dependent over the age 23). Prior authorization is required, please contact the Fund Office for approval.

B. How Vision Care Benefits Are Paid

1. The Plan pays 100% of the charge for one exam and one set of glasses (lenses and frames), up to a maximum benefit of $250 per person every two years. Vision Care Benefits Claim Forms are available from the Fund Office. You can also go to any provider of your choice, obtain services and submit a Vision Care Benefits Claim Form with a copy of the itemized bill to the Fund Office for processing. The Plan also pays 100% of the charge for laser vision correction, up to a $3,500 lifetime maximum benefit per member and one dependent over the age of 23. Your provider must contact the Fund Office for Pre-Authorization.

C. Ineligible Vision Care Expenses

1. The Plan's vision care coverage will not pay for:

- **a)** non-prescription sunglasses.
- **b)** repairs due to breakage.
- **c)** Replacement of lost eyeglasses.
- **d)** frames alone.
- **e)** insurance for breakage.
- **f)** cleaning supplies.
- **g)** lens coating & scratch resistant coatings (not covered as a separate charge).

XIII. HEARING AID BENEFITS

A. Eligible Hearing Aid Expenses

1. The Plan covers the following eligible hearing aid expenses incurred by you and your dependents:

B. How Hearing Aid Benefits Are Paid

1. The Plan pays 100% of the charge for eligible hearing aid devices, up to a $1,200 maximum benefit per ear. Benefits are payable once in any 36-month period.

2. You can go to any provider, obtain services and submit a copy of the itemized bill to the Fund Office for processing.

C. Ineligible Hearing Aid Expenses

1. The Plan's hearing aid coverage will not make payments for, or reimburse any part of, expenses incurred for, caused by, or resulting from, expenses incurred for hearing treatment or services payable under the provisions of any other benefit of the Plan. The following hearing aid expenses are excluded:

- **a)** device repairs
- **b)** fittings or molds
- **c)** testing
- **d)** batteries
- **e)** insurance

XIV. SHORT-TERM DISABILITY BENEFITS (STD)

1. The Plan's short-term disability benefits help protect you and your family from the financial consequences of illness or injury. The weekly short-term disability benefit is $120. Benefits are payable if you are unable to work because of an injury or illness and are under the care of a licensed physician.

A. When Benefits Begin

1. Whether you are absent because of an accidental injury, sickness, illness or pregnancy, benefits are payable from your eighth day of absence.

B. Duration of Benefit Payments

1. Benefits are payable for up to 26 weeks for each period of disability. The 26 week maximum applies to any one period of disability, whether from one or more causes, or for successive periods of disability due to the same or related cause or causes.

2. If your short-term disability benefits end and you return to work in covered employment and again become disabled as a result of illness or accidental injury, you may re-apply for short-term disability benefits after you work at least two weeks in covered employment.

C. How to Apply For STD Benefits

1. You can apply for STD benefits by submitting a completed STD Claim Form along with a physician's statement of your disability to the Fund Office. STD Claim Forms are available from the Fund Office. The Fund Office must receive your application within 60 days of the start of your disability. The Fund reserves the right to have your disability evaluated by a Fund approved physician.

XV. LONG-TERM DISABILITY BENEFITS (LTD)

1. The Plan's long-term disability (LTD) benefits help protect you and your family from the financial consequences of a non-work related prolonged illness or non-work related injury. The monthly LTD benefit is $400. Benefits are payable if you are considered permanently and totally disabled.

A. What Qualifies as a Long-term Disability

1. You are considered permanently and totally disabled if you meet all of the following requirements:

- **a)** During the first 36 months of disability, you are considered permanently and totally disabled if, because of injury or illness, you cannot work as an ironworker.
- **b)** After 36 months of disability, you are considered permanently and totally disabled if you are unable, because of injury or illness, to engage in any substantial gainful employment.
- **c)** You are under the care of a licensed physician.
- **d)** your disability is due to a medical illness/injury and not a work-related illness/injury.

2. If you actually start working at any substantial gainful employment during the first 36 months of disability, you will no longer be considered disabled.

3. **Medical proof.** From time to time, the Fund Office will ask you to prove that you continue to be totally disabled. If you fail to furnish proof when it is requested or if you refuse to be examined by a doctor the Plan selects and pays for, you will no longer be considered totally disabled.

CALLOUT: You are not entitled to disability benefits under this Plan if you are receiving benefits from the Iron Workers Local 11 Pension Fund.

B. When Benefits Begin

1. LTD benefits are payable when you have been totally disabled and after you have completed 26 weeks of short-term disability benefits, due to a non-work related illness or non-work related injury.

C. Receiving LTD Benefits

1. To receive benefits, contact the Fund Office and submit proof of your disability within 90 days of the date you become disabled. If you first apply for LTD benefits after this 90-day period, it will be presumed that your disability did not commence while you were working in covered employment, unless you can provide the Fund with clear and convincing evidence otherwise.

D. Duration of Benefit Payments

1. If you become disabled before your 50th birthday, Plan benefits are payable for as long as you remain disabled. If you become disabled at age 50 or later, benefits are payable until you reach age 65.

E. When Benefits End

1. LTD benefits will stop when any of the following occurrences take place:

- **a)** you are deemed to no longer be totally and permanently disabled
- **b)** the Plan receives satisfactory information that indicates you are ineligible for LTD benefits
- **c)** you die

F. What's Not Covered

1. LTD benefits are not payable for disabilities that result directly or indirectly from:

- **a)** self-inflicted injury
- **b)** addiction to narcotics or alcohol
- **c)** your commission of, or your attempt to commit a crime, an assault, battery or felony
- **d)** a disease or injury for which you received medical treatment or services, or took prescribed drugs or medicines during the 3 month period immediately before your insurance went into effect, and which, directly or indirectly, causes you to become disabled during the first 12 months you are insured
- **e)** War (whether declared or not), insurrection, rebellion or participation in a riot or civil commotion

XVI. LIFE INSURANCE BENEFITS

1. The Plan's life insurance benefits help provide your family with a measure of financial security in the event of your death. Coverage is insured by AIG Benefit Solutions.

2. Your Life Insurance coverage is $30,000. Life Insurance benefits are payable to your beneficiary if you die while coverage is in effect.

A. About Your Beneficiary

1. Your beneficiary will be the person or persons you designate in writing on a form that's kept on file at the Fund Office. You may change your designated beneficiary at any time by completing and submitting a revised form to the Fund Office. A designation or change, of beneficiary received at the Fund Office after your death will not be honored. If, however, there is a divorce decree or another court order that directs you to name a particular person as a beneficiary, you may not be able to change your beneficiary designation.

2. If you do not name a beneficiary, or if your beneficiary dies before you and you have not named a new beneficiary, your life insurance benefit will be payable in the following order:

- **a)** your wife or husband, if living
- **b)** living children, equally
- **c)** living parents, equally, and
- **d)** if none of the above, to your estate

B. If You Become Disabled

1. If you become totally and permanently disabled while insured and before age sixty (60) your life insurance will remain in force as long as you remain so disabled, provided proof of such disability are furnished as required. Notice of claim must be given to the Fund Office within twelve (12) months after the date you cease active work and the first proof should be filed with the Fund office within three months after total disability has lasted nine months. Subsequent proofs of disability must be furnished each year thereafter.

C. Conversion of Coverage

1. You may elect to buy an individual life insurance policy if your life insurance is reduced or ends because of any of the following:

- **a)** termination of employment
- **b)** termination of membership in the class or classes eligible for coverage under the policy
- **c)** termination of the policy
- **d)** attainment of a particular age
- **e)** change in class
- **f)** amendment of the policy.

2. No evidence of good health will be required for the converted policy. The converted policy may be in any of the forms the carrier issues, except:

- **a)** it may not provide term insurance except as stated below
- **b)** it may not provide benefits for disability
- **c)** it may not provide extra benefits for accidental death
- **d)** it must meet the carrier's issue rules as to amount and age.

3. You must apply to the carrier and pay the first premium for the converted policy. If you are notified of the right to convert within 15 days before or after the change in life insurance, this must be done within 31 days of the change. Then the converted policy will take effect 31 days after the change.

4. If you are not notified in that period, the time to apply to the carrier is extended to the earlier of 45 days after notice is given or 90 days after the change. Then the converted policy will take effect on the later of 31 days after the change or when the first premium is paid.

5. If you die within 31 days after the change, AIG will pay to the beneficiary, in accord with the terms of this policy, the amount of the life insurance that could have been converted.

XVII. ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS (AD&D)

1. The Plan's Accidental Death and Dismemberment insurance benefits help provide you and your family with a measure of financial security in the event of your accidental death or serious injury. Accidental Death and Dismemberment (AD&D) Insurance is in effect 24 hours a day. It is world-wide protection that applies to accidents on or off the job, at home or away from home. Coverage is insured by AIG Benefit Solutions.

A. How AD&D Benefits Work

1. Your AD&D Insurance coverage is shown below. Benefits are payable to your beneficiary if you die, or to you if you are severely injured in an accident (except those specifically excluded below). AD&D Insurance benefits are payable in addition to any other coverage you may have. Your beneficiary will be the same as your life insurance beneficiary on file with the Fund Office.

Loss	Benefit Payable	Payable to
Life	$30,000	Beneficiary
Accidental Death and Dismemberment	$30,000	Beneficiary
Occupational (on the job) Fatality	$70,000	Beneficiary
Both hands at or above the wrist; both feet at or above the ankle; eyesight in both eyes; or any combination of hand, foot and eyesight	$30,000	Member
One hand at or above the wrist; one foot at or above the ankle; or eyesight in one eye	$15,000	Member

2. How a "loss" is defined. Loss of a hand or foot means the actual and complete severance through or above the wrist or ankle joint. Loss of eyesight means the irrevocable and complete loss of sight.

3. The Fund Provides $70,000 of accidental death coverage for occupational (on the job) fatalities only. The benefit paid to beneficiaries for job site accidental deaths will be $130,000 (that is $30,000 for loss of life, plus $30,000 for accidental death and dismemberment, plus the $70,000 for Occupational Fatality). The loss must take place within 90 days after an accident for AD&D benefits to be payable. Any claim payable under the Plan must be filed within 90 days after a loss is incurred.

B. What's Not Covered

1. AD&D insurance benefits will not be paid for injuries that result from any of the following causes:

- **a)** suicide or attempted suicide;
- **b)** intentionally self-inflicted injury, including but not limited to Russian roulette;
- **c)** bodily or mental disease or treatment of these;
- **d)** the Insured's commission of or attempt to commit a felony or his engagement in an illegal occupation;
- **e)** bacterial infection except pyogenic infection which occurs through or with an accidental cut or wound;
- **f)** war or any act of war, whether declared or undeclared;
- **g)** travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft;
- **h)** voluntary poisoning; or
- **i)** the Insured's intoxication or being under the influence of any narcotic unless administered or consumed on the advice of a physician. Intoxication shall be determined as defined by the jurisdiction in which the Loss occurred.

XVIII. VACATION BENEFITS

A. HOW THE VACATION BENEFIT WORKS

Contributions are made from your wages by the purchase and distribution of Benefit Vouchers at the rate(s) established by the collective bargaining agreement between your contributing employer and Iron Workers Local 11

1. How Benefit Vouchers Work and How to Receive the Contributions Your Vouchers Represent

Your contributing employer will enclose in your pay envelope a Benefit Voucher which states the total hours for which contributions were made from your wages to your account for a stated period.

Your Vacation Benefit is paid out quarterly to you.

2. How the Vacation Benefit Is Administered

The Trustees have full authority to collect and invest contributions. Earnings on invested contributions are used to offset any administrative expenses. The administrative expenses applied to the Vacation Benefit is deducted.

B. HOW YOUR VACATION BENEFIT IS CALCULATED

The monetary value of your Vacation Benefit is the total Vacation Benefits contributed from your wages plus earnings and less administrative expenses.

1. What Else Might Affect the Amount of Your Benefit?

If you have a loan from the Iron Workers Local 11 Annuity Fund and you fail to make the current payment (due on January 1st, April 1st, July 1st and October 1st), the amount of the loan payment will be deducted from your Vacation Benefits.

C. WHAT ELSE DO YOU NEED TO KNOW?

1. What Happens If You Die?

If you die before you receive your vacation benefit, the Vacation Benefit to which you are entitled will be paid to the same beneficiary that you designate for the Welfare Fund. If no beneficiary is named for the Welfare Fund, your benefit will be paid to your surviving spouse or, if you aren’t married, to your estate.

2. Can You Assign Your Vacation Benefits?

No. You may not assign, transfer, or pledge your Vacation Benefit except as security for an Annuity Fund loan. In addition, your Vacation Benefit cannot be taken from you by legal process, attachment or garnishment except in the case of a Notice of Levy placed on your Vacation Benefit by the Internal Revenue Service.

XIX. CLAIMS AND APPEALS PROCEDURES

1. This section describes the procedures for filing claims for benefits from the Plan. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

A. How to Receive Benefits under the Plan

1. Below are details about the Plan's Reasonable Claims Procedures which describe how to receive benefits under this Plan and how and where to file claims. In general, under the Plan's rules, simple inquiries about the Plan's benefit provisions or eligibility that are unrelated to any specific benefit claim will not be treated as a claim for benefits. A request for prior approval of a benefit that does not require prior approval by the Plan is also not considered a claim for benefits.

2. Benefits received from medical providers and hospitals are generally not considered "claims" under these procedures because hospitals and medical providers generally submit them directly to Horizon Blue Cross Blue Shield. However, if your request for any of these benefits is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

B. When and How Claims Must Be Filed

1. All claims are considered for payment when they are received by the organization that is responsible for administering the benefit as listed below. All hospital, medical, supplemental Medicare, dental, vision, and hearing aid claims must be filed within one year from the date the charges were incurred. Short-term disability claims must be filed within 60 days of the date of the onset of the disability. Long-term disability, accidental death and dismemberment and life insurance claims should be filed as soon as possible. Failure to file claims within the time required will not invalidate or reduce any claim if it was not reasonably possible to file the claim within such time.

2. Filing hospital and medical claims. You are generally not required to submit a claim form in order to be reimbursed for hospital and medical benefits because most hospital and medical claims are submitted directly to Horizon Blue Cross and Blue Shield of New Jersey by the hospital or medical provider. If you need to submit a claim, you must obtain the claim form from Horizon Blue Cross Blue Shield of NJ or the Fund Office and submit it directly to:

Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1609
Newark, NJ 07101-1609
1-800-355-2583

3. Filing mental health and substance abuse benefit claims. You do not have to submit a claim form in order to obtain mental health and substance abuse benefits. However, you must contact Managed Health Network at 1-800-327-6517 for authorization to use an in-network provider prior to receiving these benefits. No benefits will be payable for inpatient mental health and substance abuse benefits if you fail to contact Managed Health Network.

4. Filing retail prescription drug claims. You must follow the instructions below for prescription reimbursements:

a) **Using a Participating Pharmacy.** When you use a participating pharmacy, you will receive a discounted rate on prescribed drugs. Your cost will be a 10% copayment as discussed on page 53. Copayments are the patient's responsibility and is not reimbursable by this Plan. If this is a copayment paid under the spouse's primary carrier, an Explanation of Benefit Statement and proof of payment is required for reimbursement of copayment.

b) **Using a Non-Participating Pharmacy.** If you use a non-participating pharmacy, you will be charged the full retail price for the drugs and you will not be reimbursed by the Fund Office or Benecard PBF.

c) **Benecard PBF Mail Order Service.** When you use Benecard PBF (the mail order program), you will receive up to a 90-day supply of maintenance medication. All drugs, whether generic or brand name, are subject to the required co-payment. If you order a brand name drug with a generic equivalent, you will have to pay the difference between the cost of the brand name drug and its generic equivalent, in addition to the required co-payment. Please note that all prescriptions for maintenance drugs should be submitted to Benecard PBF, Benecard Central Fill, P.O. BOX 779, Mechanicsburg, PA 17055-0779.

5. Filing dental, vision and hearing aid claims. You must submit a completed claim form along with an itemized bill to receive dental, vision, and hearing aid benefits. Claim forms are available from the Fund Office at:

Iron Workers Local 11
Welfare Fund
12 Edison Place
Springfield, New Jersey 07081

6. Filing short-term disability (STD) claims. In order to file a claim for STD benefits offered under this Plan, you must submit a completed claim form along with the attending physician's statement within 60 days of the date of the onset of the disability to the Fund Office. Claim forms are available from the Fund Office at the address above. If you fail to furnish proof of disability when it is requested, your benefits will cease. No benefits are payable for any period during which you are not under the care of a legally qualified physician.

7. Filing long-term disability (LTD) claims. In order to file a claim for LTD benefits offered by the Plan, you must submit a completed claim form along with proof of your disability as soon as possible to the Fund Office. Claim forms are available from the Fund Office at the address above. Proof of your continued total disability will be required at reasonable intervals. If you fail to furnish proof when it is requested or you refuse to be examined by a Fund physician, your benefits will cease.

8. Filing life and accidental death and dismemberment (AD&D) insurance claims. If you are the victim of an accidental dismemberment, you or your authorized representative must call the Fund Office as soon as possible to find out the documentation and information the Fund will need in order to submit a claim on your behalf. Upon receipt of the necessary documentation and information, the Fund Office will complete a claim form and submit it to AIG Benefit Solutions for you.

If you should die from accidental or natural causes, your beneficiary or the executor of your estate (if there is no beneficiary) must provide the Fund with certain documentation and information to enable the Fund to submit a claim to AIG Benefit Solutions. The beneficiary or executor should call the Fund Office as soon as possible to find out what is needed. Upon receipt of the necessary documentation and information, the Fund will complete a claim form and submit it to AIG Benefit Solutions on behalf of your beneficiary or the executor of your estate.

9. If you think your Vacation Benefit is incorrect, call the Fund Office so that a review may be made of the amount processed. Then, if an error is discovered it can be corrected. If you do not receive a benefit to which you believe you are entitled, you should file a claim with the Plan Administrator at the address given in this booklet.

C. Authorized Representatives

1. An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Claim (defined below) without you having to complete the special authorization form.

D. Types of Claims

1. The claims procedures for benefits will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, a Post-Service Claim, or a Disability Claim. The claims procedures for Life Insurance and AD&D benefits will also vary. Read each section carefully to determine which procedure is applicable to your request for benefits.

E. Pre-Service Claims

1. A Pre-Service Claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before medical care is obtained. Under this Plan, prior approval of services is required for inpatient hospital benefits, certain outpatient hospital benefits, mental health and substance abuse benefits and certain dental benefits, as described in your SPD.

2. In order to pre-certify in-patient hospitalizations, call Horizon's pre-admission review and emergency admission at 1-800-355-2583 before your admission. If it is an emergency admission, you must notify pre-admission review within 48 hours of the admission.

3. You must contact Managed Health Network at 1-800-327-6517 before you receive in-patient mental health and substance abuse benefits in order to obtain an authorization to a participating provider or hospital. If you fail to contact Managed Health Network, or use a non-participating (out-of-network) provider or hospital, no benefits will be payable.

4. You or your dentist must mail a treatment plan with x-rays to the Fund Office for pre-determination prior to obtaining major dental services.

5. For properly filed Pre-Service Claims, you and/or your doctor or dentist will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of Horizon's pre-admission review and emergency admission, Managed Health Network or the Fund Office (for dental pre-determination). You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

6. If you improperly file a Pre-Service Claim, you will be notified as soon as possible but not later than after receipt of the claim, of the proper procedures to be followed in filing a claim. You will only receive notice of an improperly filed Pre-service claim if the claim includes (i) your name, (ii) your current address, (iii) your specific medical condition or symptom, and (iv) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

7. If an extension is needed because Horizon's pre-admission review and emergency admission, Managed Health Network or the Fund Office needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor or dentist will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). Horizon's pre-admission review and emergency admission, Managed Health Network or the Fund Office then have 15 days to make a decision on a Pre-Service Claim and notify you of the determination.

F. Urgent Care Claims

These procedures only apply to hospital and mental health and substance abuse benefits.

1. An Urgent Care Claim is any claim for medical care or treatment with respect to which the application of the time periods for making pre-service claim determinations:

- **a)** could 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, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim

2. Whether your claim is an Urgent Care Claim is determined by Horizon's pre-admission review and emergency admission or Managed Health Network by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above shall be treated as an Urgent Care Claim.

3. If you improperly file an Urgent Care Claim, you will be notified as soon as possible but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

4. If you are requesting utilization management of an Urgent Care Claim, the time deadlines are different. Horizon's pre-admission review and emergency admission or Managed Health Network will respond to you and/or your doctor with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the organization responsible for the claim. The determination will also be confirmed in writing.

5. If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, Horizon's pre-admission review and emergency admission or Managed Health Network will notify you and/or your doctor as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within 48 hours. If the information is not provided within that time, your claim will be denied.

6. Notice of the decision will be provided no later than 48 hours after the organization receives the specified information or the end of the period given for you to provide this information, whichever is earlier.

G. Concurrent Claims

1. A Concurrent Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. (An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

2. A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by plan amendment or termination) will be made by the organization as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

3. Any request by a claimant to extend approved Urgent Care treatment will be acted upon by Horizon's pre-admission review and emergency admission or Managed Health Network within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

H. Post-Service Claims

1. A Post-Service Claim is a claim that is not a Pre-Service Claim (for example, a claim submitted for payment after health services and treatment have been obtained).

2. Ordinarily, you will be notified of the decision on your Post-Service claim within 30 days from receipt of the claim by the organization responsible for paying the claim. This period may be extended one time by the applicable organization for up to 15 days if the extension is necessary due to matters beyond the control of the organization responsible for making the determination. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the organization expects to render a decision.

3. If an extension is needed because the organization needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The organization responsible for paying the claim will then have 15 days to make a decision on a Post-Service Claim and notify you of the determination.

I. Disability Claims

1. For Disability Claims, whether short-term or long-term, the Fund Office will make a decision on the claim and notify you of the decision within 45 days. If the Fund Office requires an extension of time due to matters beyond its control, the Fund Office will notify you of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 45-day period. A decision will be made within 30 days of the time the Fund Office notifies you of the delay. The period for making a decision may be delayed an additional 30 days, provided the Fund Office notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund Office expects to render a decision.

2. If an extension is needed because the Fund Office needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). Once you respond to the Fund Office's request for the information, you will be notified of the Fund's decision on the claim within 30 days.

J. AD&D and Life Insurance Claims

1. AIG Benefit Solutions provides coverage for AD&D and Life Insurance Benefits.

2. If you are the victim of an accidental dismemberment, you or your authorized representative must call the Fund Office as soon as possible to find out the documentation and information the Fund will need in order to submit a claim on your behalf. Upon receipt of the necessary documentation and information, the Fund Office will complete a claim form and submit it to AIG Benefit Solutions for you.

3. Upon notification of your death from natural or accidental causes, the Fund Office will contact your designated beneficiary or the executor of your estate (if there is no beneficiary) to obtain the required information and documents necessary for the submission of a claim to AIG Benefit Solutions. The Fund Office will submit the claim to AIG Benefit Solutions for processing on behalf of your beneficiary or the executor of your estate, as applicable, upon receipt of the required documentation and information.

4. In cases of both AD&D and Life Insurance Claims, AIG Benefit Solutions will make a decision on the claim and notify the Fund Office of the decision within 90 days. If AIG Benefit Solutions requires an extension of time due to matters beyond its control, AIG Benefit Solutions will notify the Fund Office of the reason for the delay and when the decision will be made. This notification will occur before the expiration of the 90-day period. The Fund will then notify you, your authorized representative, your beneficiary or the executor of your estate, as applicable, of the delay and due date. A decision will be made within the 90-day extension period.

K. Notice of Decision

1. You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- **a)** The specific reason(s) for the determination.
- **b)** Reference to the specific Plan provision(s) on which the determination is based.
- **c)** A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.
- **d)** A description of the appeal procedures (including voluntary appeals, if any) and applicable time limits.
- **e)** A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- **f)** If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive a statement that the rule is available upon request at no charge.
- **g)** If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim is available upon request at no charge.
- **h)** For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.

2. For Urgent Care Claims and Pre-Service Claims, you will receive notice of the determination even when the claim is approved.

L. Request for Review of Denied Claim

1. If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Board of Trustees within after 180 days you receive notice of denial, except for the following appeals which should be submitted to the applicable organization, as noted:

a) Appeals involving Hospital Pre-Service or Urgent Care Claims may be made orally by calling Horizon pre-admission review and emergency admission service at 1-800-355-2583.

b) Appeals involving mental health and substance abuse Pre-Service or Urgent Care Claims may be made orally by calling Managed Health Network at 1-800-327-6517. Written appeals may be submitted to the following address:

Managed Health Network
Appeals Unit
1600 Los Gamos Drive
San Rafael, CA 94903

c) Appeals for Post-Service Hospital and Medical Claims should be submitted directly to:

Horizon Blue Cross Blue Shield of New Jersey
P.O. Box 1609
Newark, NJ 07101
(Phone 1-800-355-2583).

d) All other appeals for, dental, vision, hearing aid, prescription drug, Post-Service mental health and substance abuse, disability, AD&D and life insurance claims, and the second level appeal for hospital and medical claims should be submitted to the:

Iron Workers Local 11 Welfare Fund
12 Edison Place
Springfield, New Jersey 07081
Attn: Board of Trustees

M. Review Process

1. You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.

2. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the organization responsible for the initial determination of your claim, without regard to whether their advice was relied upon in deciding your claim.

3. A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

4. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

N. Timing of Notice of Decision on Appeal

a) Pre-Service Claims: There is a two-level appeals process. You will be sent a notice of decision on review within *15 days* of receipt of the appeal by Horizon's pre-admission review and emergency admission, Managed Health Network or the Fund Office. If you disagree with the decision, you may submit a second written appeal within *180 days* of receipt of the first decision. Horizon's pre-admission review and emergency admission, Managed Health Network or the Fund Office has *15 days* in which to make a decision.

b) Urgent Care Claims: There is a one-level appeals process. You will be sent a notice of a decision on review within *72 hours* of receipt of the appeal by Horizon's pre-admission review and emergency admission or Managed Health Network.

c) **Post-Service Hospital and Medical Claims:** There is a two level review for post-service Hospital and Medical claims. You will be sent a notice of a decision by Horizon within *30 days* for the first level of appeal. If you are dissatisfied with the decision of the first appeal, you may submit a second appeal to the Board of Trustees within *180 days* of the receipt of the first decision. You will be sent a notice of a decision by a Sub-committee of the Board of Trustees within *30 days* of receipt for the second level of appeal.

d) **All Other Post-Service Claims:** Ordinarily, decisions on appeals involving Post-Service Claims will be made by a Sub-committee of the Board of Trustees prior to the next regularly scheduled meeting of the Board following receipt of your request for review. However, if your request for review is received within *30 days* of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than *5 days* after the decision has been reached.

e) **STD and LTD Claims:** You will be sent a notice of a decision on review within *45 days* of receipt of the appeal by the Board of Trustees.

f) **Life Insurance and AD&D Claims:** You will be sent a notice of a decision on review within 60 days of receipt of the appeal by the Board of Trustees. If the Board determines that special circumstances require an extension of time to process the appeal, it will notify you, your authorized representative, your beneficiary, the executor of your estate, as applicable, of the reason for the delay and when the decision will be made. A decision will be made within the 60 day extension period.

O. Notice of Decision on Review

1. The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- **a)** The specific reason(s) for the determination.
- **b)** Reference to the specific plan provision(s) on which the determination is based.
- **c)** A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
- **d)** A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- **e)** A statement that if an internal rule, guideline or protocol was relied upon by the Plan, it is available upon request at no charge.
- **f)** If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, is available upon request at no charge.
- **g)** A statement that 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.

P. Limitation on When a Lawsuit May Be Started

1. You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than three (3) years after the end of the year in which medical or dental services were provided, or, if the claim is for short-term disability benefits, more than three (3) years after the start of the disability.

Q. Reciprocal Claims

1. These rules apply when filing claims for benefits under a reciprocity agreement:

a) File claims for benefits with your Home Fund as long as your service with the Home Fund is enough to meet its eligibility requirements, even though you may be working in the jurisdiction of a Cooperating Fund when you file your claim.

b) File claims for benefits with a Cooperating Fund if you have lost your eligibility status with your Home Fund but have been working in the jurisdiction of the Cooperating Fund for a period long enough to meet its eligibility requirements.

c) Where you do not meet the eligibility requirements of either your Home Fund or a Cooperating Fund, you should file claims for benefits with your Home Fund. In this instance, Point of Claim Reciprocity becomes effective. Your service with a Cooperating Fund(s) will be used towards meeting the eligibility requirements of your Home Fund. You will not be entitled to benefits from any of the Funds if your service, including service with Cooperating Funds, is not enough to re-establish eligibility with your Home Fund.

2. In filing claims for benefits with your Home Fund, indicate all Cooperating Funds in whose jurisdiction you have worked. Contact the Fund Office to determine if a welfare fund is a Cooperating Fund with your Home Fund.

3. If you have worked outside the jurisdiction of this fund and have or expect to have a medical claim, contact the Fund Offices of the other Fund(s) to determine what type of reciprocity you are entitled to.

XX. OTHER INFORMATION YOU SHOULD KNOW

This section contains other important information you should know about the Welfare Fund.

A. Confidentiality

1. The Welfare Fund is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services. The official HIPAA Privacy Notice, which is distributed to all Fund participants, is summarized here.

2. The main idea of HIPAA is to make sure that private health information that identifies (or could be used to identify) you is kept private. This individually identifiable health information is known as "protected health information" (PHI). The Plan will not use or disclose your protected health information without your written authorization except as necessary for treatment, payment, Plan operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any Plan benefit.

3. The Plan also hires professionals and other companies to advise the Plan and help administer and provide health care benefits. The Plan requires these individuals and organizations, called "Business Associates," to observe HIPAA's privacy rules. In some cases, you may receive a separate notice from one of the Plan's Business Associates (for example, MHN). That notice will describe your rights with respect to benefits administered by that individual/organization.

4. Under federal law, you have certain rights where your protected health information is concerned, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, change or correct the information. You have the right to request reasonable restrictions on disclosure of information about you, and to request confidential communications. You also have the right to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services if you believe your rights have been violated.

5. If you have questions about the privacy of your health information or if you would like a copy of the official HIPAA Privacy Notice, please contact Beatriz Ventura, who is the Fund's Privacy Officer, at the Fund Office.

B. Financing

1. Paying for the Welfare Fund. Contributions to the Fund come from employers who have collective bargaining agreements with Local 11 that provide for contributions to the Fund. In addition, there are certain other plans in other geographic areas with which this Fund has reciprocal agreements. This means that if you work in the jurisdiction of one of these other funds in employment covered by the other fund, the other plan will contribute to this Fund as long as you complete and return the required reciprocal form.

2. Managing Fund money. All of the Fund's money is held in trust by the Board of Trustees of the Fund for the benefit of the participants and beneficiaries of the Fund. The Board of Trustees has the ultimate responsibility for managing Fund money.

3. What happens to Fund money if the Fund is discontinued. The assets of the Fund must be used only for the benefit of the participants and beneficiaries. If the Fund is discontinued and there is still money left over after the Fund has met all of its obligations to pay benefits, the money must be used to provide additional benefits. Under no circumstances may money which has been properly contributed to the Fund ever be returned to any employer or be transferred to the Ironworkers Local 11 Benefits Fund and Training facility.

4. To find out whether a particular employer is contributing to the Fund on behalf of members working under a collective bargaining agreement or a participation agreement and, if so, to which plan of benefits the employer is contributing, contact the Fund Office. You can look at the collective bargaining agreements at the Fund Office or get your own copy upon written request to the Fund Office.

C. How Benefits Can Be Reduced, Delayed or Lost

1. There are certain situations under which benefits can be reduced, delayed or lost. Most of these circumstances are spelled out in the previous sections, but your benefits will also be affected in the following situations.

- **a)** You or your beneficiary do not file a claim for benefits properly or on time.
- **b)** You or your beneficiary do not furnish the information required to complete or verify a claim.
- **c)** You or your beneficiary do not have your current address on file with the Fund Office.
- **d)** If your employer is no longer required to make contributions to the Fund for employees in your classification and you continue working for that employer in that classification, you will get no Vouchers for your work.

2. You should also be aware that benefits are not payable for enrolled dependents who become ineligible.

3. Notwithstanding any other provision of the Fund to the contrary, any person who receives a benefit (including a payment) under the Fund shall be required to repay to the Fund: (1) any erroneous payment made to or on behalf of such person, including the value of any benefit erroneously provided, whether due to administrative mistake or otherwise; (2) appropriate interest; and (3) in the case of fraud or misrepresentation or in the event repayment is contested, any and all costs of collection (including attorney's fees). In addition, the Trustees may take any reasonable action to recoup such erroneous payment or benefit, together with interest, and where applicable, costs, and including, without limitation, by offsetting future benefits and/or payments.

D. Coordination of Benefits

1. Medicare. For all covered, active employees and all active employee's dependents who are under age 65 and who are eligible for coverage under Medicare due to a disability, this Plan will provide health care benefits first and Medicare will be the second payer. For all age-65-and-over dependents of age-65-and-over active employees, this Plan will provide health care benefits first and Medicare will be the second payer.

2. End-stage renal disease. For covered employees who contract end-stage renal disease, Medicare will become the secondary payer of benefits during the first 30 months of treatment. After this 30-month period is over, Medicare permanently becomes the primary payer for persons with end-stage renal disease. This is true even if Medicare would be secondary for some other reason (for example, if the person was age 65 or over and becomes eligible for Medicare secondary treatment either as an actively employed person or as the spouse of such person).

3. No-fault benefits. If a person covered by this Plan has a claim which involves a motor vehicle accident covered by the "No-Fault" insurance law of any state, health care expenses must be reimbursed first by the "No-Fault" insurance carrier. Only when the claimant has exhausted his health care benefits under the "No-Fault" coverage will she/he be entitled to receive health care coverage under this Plan. If there are expenses for services which are covered under this Plan and which are not completely reimbursed by the "No-Fault" carrier, this Plan will consider for reimbursement claims for the difference, subject to the Plan's applicable maximums and other provisions.

4. Other health care plans. In the event the covered person has coverage under another employer-sponsored plan that provides health care benefits, our Plan will coordinate benefits with the other Plan. This coordination will apply in the event a covered expense is incurred under this Plan which also is covered under another plan or plans. A determination will be made as to which plan is the "primary" plan. The rules for determining which plan is primary are as follows:

a) If the other plan does not have a coordination of benefits provision with regard to the particular expense, that plan is always primary.

b) The plan that covers the patient as an active employee is primary and the plan that covers the patient as a dependent is secondary.

c) If the patient is a dependent child of parents not separated or divorced, then the plan covering the parent whose birthday falls earlier in the calendar year pays first. If the other plan does not use the "birthday rule", then that plan is primary unless the primary plan is already determined under the preceding rules 1 or 2. In the event of a divorce or separation, dependent children may be covered under more than one plan. In this case, the plan of the parent with custody will be primary; the other parent's plan will be secondary. In the event the parent with custody has remarried, the plan of the parent (or stepparent) with custody will be primary and the plan of the parent without custody will be secondary. If there is a court decree giving one parent financial responsibility for the medical expenses, then that parent's plan becomes primary.

d) If the other plan has a provision that it is always secondary, then this plan will be primary in coordination with such plan.

e) If none of the above rules establishes which plan is the primary plan, the plan that has covered the patient the longest, continuously, in the period of coverage in which the expense is incurred is the primary plan. If this Plan is the primary plan, it will pay its benefits as if there were no other plan.

5. If this Plan is the primary plan, it will pay its benefits as if there were no other plan.

6. If this Plan is not the primary plan, it will pay its benefits as if there were no other plan, except that this Plan will pay no greater part of a charge covered by this Plan and another plan(s) than that which when added to the part(s) payable by the other plan(s) equals 100% of such charge.

7. Third-party liability cases. The purpose of this Section is to insure that the limited funds available to finance the benefits provided by the Fund are not used to provide benefits where other funds may be available to pay the cost of the benefits provided by the Fund. In furtherance of this purpose, in the event that he Fund has made, does make or is obligated to make payments to or on behalf of a Participant or Dependent ("Covered Person") arising out of any Illness or Injury then, as a condition for receiving benefits from the Fund, the Covered Person shall:

a) Notify the Fund, in writing, that a Claim relating to such Illness or Injury has been filed by the Covered Person against a third party seeking Available Funds,

b) Notify the Fund, in writing of the name and address of the Covered Person's attorney, provide the attorney with a copy of this Section and any Subrogation/Reimbursement Agreement ("Agreement") the Fund may require the Covered Person to sign an order to receive benefits and require that the attorney comply with the terms of this Section and of any such Agreement.

c) Keep the Fund informed, in writing, of the progress and/or settlement of his/her Third Party Claim.

d) Include in all Claims, a claim for benefits paid by the Fund to or on behalf of the Covered Person and/or claimed from the Fund by or on behalf of the Covered Person.

e) Specifically grant the Fund a first right of reimbursement and reimburse the Fund that portion of the available funds which is due to the Plan for benefits paid to or on behalf of the Covered Person as well as for any premiums and other payments paid on behalf of the Covered Person to continue health insurance and/or other coverage pursuant to any Disability Eligibility Credit provisions of the Fund. The right of reimbursement granted to the Fund by the Covered Person includes the right of the Fund to seek reimbursement from any person or entity that holds the available funds, including by not limited to, a legal guardian, representative, trustee, parent or dependent.

f) Specifically grant to the Fund subrogation and all rights of recovery and causes of action that the Covered Person may have against the third-party, whether by suit, settlement or otherwise, that may be liable for the Covered Person's Illness or Injury for which the Fund has paid or is obligated to pay benefits on the Covered Person's behalf.

g) Hold in trust for the Fund's benefit that portion of the total recovery from any source that is due for payments made or to be made. The Covered Person shall reimburse the Fund immediately upon recovery.

h) Do nothing to impair, release, discharge or prejudice the Fund's rights to subrogation and/or reimbursement. The Covered Person shall assist and cooperate with representatives the Fund designates. The Covered Person shall do everything necessary to enable the Fund to enforce its subrogation and reimbursement rights.

i) Require an authorize Covered Person's attorney, if any, to withhold from available funds any monies due the Fund pursuant to this Section and/or the Agreement and to forward them to the Fund as required by this Section and/or the Agreement. In case of any dispute over what monies are due the Fund, available funds shall be escrowed pending resolution of such dispute.

Counsel Fees. The Fund shall have no obligation to pay any attorney's fees to any attorney retained by the Covered Person to pursue Third Party Claims or to have any attorney's fees or costs withheld from amounts due to the Fund. The Fund shall not be bound by any agreement to the contrary made by the Covered Person. The Covered Person shall be solely responsible for paying all legal fees and expenses in connection with any recovery and the Fund's recovery shall not be reduced by such legal fees or expenses unless the Fund Administrator, in his sole discretion, agrees in writing to discount the Fund's claim.

Right to set-off. The Covered Person agrees that in the event that the Covered Person fails or refuses to comply with the provisions of this Section and/or the Agreement, then the Fund, in addition to any other rights to which the Fund or the Trustees thereof might have, shall have the right to withhold from any payments due to which become due to the Covered Person or to third parties on behalf of the Covered Person any amounts necessary until the Fund is fully reimbursed as described in this Section and/or the Agreement.

Recording or use. The Covered Person hereby authorizes the Fund to record and/or use this Section and/or the Agreement in any proceedings involving the Covered Person including using this Section and/or the Agreement in any Third Party Claims that the Covered Person may have.

Authorization to pay. The Covered Person hereby authorizes any person or entity paying Available Funds to or on behalf of this Covered Person to pay over to the Fund such monies as the Fund is entitled to under this Section and/or the Agreement and this Section and/or the Agreement shall constitute their warrant to do so. In case of any dispute over what monies are due the Fund, Available Funds shall be escrowed pending resolution of such dispute.

Minors. Any Covered Person making a Claim on behalf of any minor child under the Fund's plan of benefits shall make the Agreement on behalf of said minor child and agrees that he/she is authorized to make the Agreement on behalf of said minor child.

Other Insurance. It is agreed that any payment received by a Covered Person from any insurance carrier, from Blue Cross, from Blue Shield or from any like or similar plan for which the Covered Person has paid the full premium in order to secure individual, as distinguished from group coverage, shall be excluded from the requirements of this Section and/or the Agreement.

Rejection of make-whole doctrine. The application of the make-whole doctrine is specifically disavowed by the Fund and by the Covered Person. The Covered Person agrees that the Fund's right to reimbursement, as set forth above, takes first priority on a first-dollar basis over any other claims, regardless of whether or not Covered Person has been fully compensated for all claims for damages or whether the Available Funds include payment for medical or non-medical expenses or are so characterized.

Equitable Lien/Constructive Trust. By making payments on behalf of the Covered Person, the Fund is granted an equitable lien by agreement and constructive trust over the Available Funds, to which the Covered Person consents.

Rejection of Common Fund doctrine. Covered Person agrees to the Fund's express rejection of Common Fund doctrine. The Fund's reimbursement and subrogation rights apply to any recovery by a Covered Person without regard to legal fees and expenses of the Covered Person.

For purposes of this Section, the following terms shall be defined as follows:

a) The term **"Covered Person"** shall have the same meaning as Section of this Summary Plan Description and shall also include any dependent and/or beneficiary of any Covered Person who may be entitled to benefits under the terms of the plan of benefits, as well as any parent(s), heir(s), estate(s), trust(s), guardian(s), representative(s) and any other person or entity that may be entitled to or that may receive a benefit from the Fund.

b) The term "Illness or Injury" shall mean any illness or injury of whatever kind or description, whether arising out a work related cause or whether unrelated to work of the Covered Person.

c) The term **"Available Funds"** shall mean monies recovered from third parties through a lawsuit, settlement or otherwise (whether called pain and suffering, weekly indemnity, workers compensation, damages, restitution, wage loss, medical reimbursement, out of pocket expenses or any other term) as a result of the injury or illness.

d) The terms "Claim" or "Third Party Claim" shall mean any claim for monetary or non-monetary compensation of whatsoever kind of description whether made by petition (e.g. workers' compensation petition), court complaint, insurance claim or whether merely by written or oral demand.

E. Qualified Medical Child Support Orders

1. If a court has issued an order with respect to health coverage for your dependent child(ren), the Fund Office or its designee shall determine if the court order is a Qualified Medical Child Support Order (QMCSO) as defined by federal law. The Plan will notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the dependent child(ren). However, no coverage will be provided for any dependent child pursuant to a QMSCO unless all of the Plan's requirements for coverage of that dependent child have been satisfied. If you, your child, or the child's custodial parent or legal guardian would a like a copy of the Plan's written procedures for QMCSOs, or have any questions, please contact the Fund Office.

F. Claim Fraud

1. In addition to remedies that the Plan may seek (see Section XIX.c), any participant who willfully and knowingly engages in an activity intended to defraud the Plan will face loss of Plan coverage. Furthermore, any participant who receives money from the Plan to which he or she is not entitled will be required to fully reimburse the Plan, and (per Section XIX.c) pay appropriate interest and costs of collection (including attorney fees).

2. The Fund Office regularly evaluates claims to detect fraud or false statements. The Fund Office must be advised of any discounts or price adjustments made to you by any provider. A provider who waives or refunds copayments is entering into a discount arrangement with you. The Fund Office calculates the benefit payment based on the amount actually charged, less any discounts, rebates, waivers, or refunds of copayments or deductibles you receive. Failure to notify the Fund Office of such price adjustments may result in an overpayment of benefits and constitutes a serious violation of the provisions of the Plan. If a claim has been submitted for payment or paid by the Plan as a result of fraudulent representations, the Fund Office may seek reimbursement and may elect to pursue the matter by pressing criminal charges.

G. Assignment of Benefits

1. You cannot assign or transfer benefits, in any manner nor to any extent, to anyone other than a health services provider (which you do by completing a form provided by the Fund). You cannot pledge the benefits owed to you for the purpose of obtaining a loan.

2. To the extent permitted by law, the benefits or payments under the Plan shall not be assignable or otherwise transferrable, nor subject to any claim of any creditor of any individual covered under the Plan or to legal process by any creditor of any individual covered by the Plan, except pursuant to a Qualified Medical Child Support Order.

H. Compliance With Federal Law

1. The Plan is governed by regulations and rulings of the Internal Revenue Service and the Department of Labor, and current federal tax and labor law. The Plan will always be construed to comply with these regulations, rulings and laws. Generally, federal law "pre-empts" (that is, takes precedence over) state law.

I. Amendment or Termination of the Plan

1. This Summary Plan Description describes the benefits the Fund provides to participants (including employees, retirees and dependents) and the circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of benefits that a participant might otherwise reasonably expect a plan to provide.

2. The benefit provisions and eligibility rules that apply to employees, retirees and dependents have been established by the Board of Trustees as part of an overall benefit program for participants. The Board of Trustees reserves the right to amend, modify, suspend or terminate the eligibility rules and plan of benefits for employees, retirees and dependents at any time, in accordance with the responsibilities and authority assigned to the Board by the Agreement and Declaration of Trust.

3. In accordance with the rules and regulations of the Plan and the Trust Agreement, no employee, retiree or dependent has a vested right or contractual interest in the benefits provided. In addition to the right to terminate participants' benefits at any time, the Board of Trustees also reserves the right, in the event of termination of the Welfare Fund, to terminate the program of benefits for employees, retirees and dependents, and there shall not be any vested right of any employee, retiree, dependent or beneficiary, nor contractual rights, after the disposition of all Plan assets and the termination of the Fund. Employees, retirees and dependents shall have no priority with respect to the disposition of Fund assets in connection with the termination of this Welfare Fund. The provisions for employees', retirees' and dependents' coverage will be reviewed annually by the Board of Trustees.

J. Fund Administration

1. The Iron Workers Local 11 Welfare Fund is what the law calls a "welfare plan." Plan benefits are provided from the Fund's assets. Those assets are accumulated under the provisions of the Trust Agreement and are held in a Trust Fund for the purpose of providing benefits to participants and defraying reasonable administrative expenses. The Fund is administered by a joint Board of Trustees consisting of Union Trustees and Employer Trustees with equal voting power.

K. Interpretation of the Plan

1. The Trustees have the sole and absolute discretionary authority to interpret the terms of the Plan, determine benefit eligibility, and resolve ambiguities or inconsistencies in the Plan. All determinations and interpretations made by the Board of Trustees and/or its duly authorized designee(s) shall be final and binding upon all participants, beneficiaries and any other individuals claiming benefits under the Plan.

2. The Board of Trustees has delegated certain administrative and operational functions to the staff of the Fund Office. Most of your day-to-day questions can be answered by the Fund Office staff.

L. Independent Contractors

1. The relationship between Horizon Blue Cross Blue Shield or MHN and hospitals, facilities or providers is that of independent contractors. Nothing in Horizon Blue Cross Blue Shield's or MHN's contracts shall be deemed to create between Horizon Blue Cross Blue Shield or MHN and any hospital, facility or provider (or agent or employee thereof) the relationship of employer and employee or of principal and agent. Horizon Blue Cross Blue Shield or MHN will not be liable in any lawsuit, claim or demand for damages incurred or injuries that you may sustain resulting from care received either in a hospital/facility or from a provider.

M. No Liability for Practice of Medicine

1. Neither the Plan, the Fund Administrator nor any of their designees are engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, the Fund Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

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

A. Information About Your Plan and Benefits

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

- **a)** Examine, without charge, at the Fund Office and at other specified locations, such as work locations and union halls, all documents governing the Welfare Fund, including the official Plan Description, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration (formerly the Pension and Welfare Benefits Administration).

- **b)** Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

2. You are entitled to continue health care coverage for yourself, your spouse or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this booklet and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

B. Prudent Actions by Plan Fiduciaries

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

C. Enforce Your Rights

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

2. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual reports from the Plan, and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

3. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court (but only after you have followed the appeals procedures described on page 88). In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

D. Assistance with Your Questions

1. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries Employee
Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W. Washington D.C, 20210

2. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XXII. PLAN FACTS

Official Plan Name
Iron Workers Local 11 Welfare Fund

Employer Identification Number
(EIN) 22-6041517

Plan Number
501

Plan Year
July 1 – June 30

Type of Plan
Welfare Benefits Plan, including medical, mental health and substance abuse, dental, prescription drug, vision care, life insurance, AD&D, short-term disability, and long-term disability benefits.

Funding of Benefits
All contributions to the Welfare Fund are made by contributing employers in accordance with applicable collective bargaining agreements. Benefits are paid from the Fund's assets, which are accumulated under the provisions of the written agreements and the Trust Agreement. Earnings on invested contributions help pay for administrative expenses.

Trust
Assets are held in a Trust Fund for the purpose of providing benefits to covered participants and paying reasonable administrative expenses.

Plan Sponsor and Administrator
The Iron Workers Local 11 Welfare Fund is administered by a joint Board of Trustees. The office of the Board of Trustees may be contacted at:

> Iron Workers Local 11 Welfare Fund
> 12 Edison Place
> Springfield, NJ 07081-1310

Agent for Service of Legal Process
The Board of Trustees has been designated as the agent for the service of legal process. Legal process may be served at the Fund Office and on the individual Trustees.

A. ADMINISTRATIVE CONTACTS

Medical and Major Medical
Horizon Blue Cross Blue Shield of New Jersey
P.O. BOX 1609
Newark, NJ 07101
1-800-355-2583

Prescription Drug
Benecard PBF
5040 Ritter Road
Mechanicsburg, PA 17055
1-888-907-0070

Mental Health and Substance Abuse
Managed Health Network
Appeals Unit
1600 Los Gamos Drive Suite 300
San Rafael, CA 94903
1-800-327-6517

Life Insurance
AIG Benefit Solutions
3600 Route 66
P.O. Box 1580
Neptune, NJ
1-800-250-8898

Policy No. G255791

Accidental Death & Disability
AIG Benefit Solutions
Accidental & Health Claims Department
P.O. Box 25987
Shawnee Mission, KS 66225
1-800-551-0823

Policy No. BSC0009137656

XXIII. GLOSSARY

Adverse Benefit Determination – an adverse benefit determination is any denial, reduction or termination of, or failure to provide or make payment for (in whole or in part), a benefit, including one based on a determination of eligibility, as well as one based on the application of any utilization review criteria, including determinations that an item or service for which benefits are otherwise provided are not covered because they are deemed to be experimental/investigational or not medically necessary or appropriate.

Allowance - Actual charges of a Provider or a dollar amount set by the Plan, unless otherwise required by law.

Benefit Period – the twelve-month period starting on January 1st and ending on December 31st. The first and/or last Benefit Period may be less than a calendar year. The first Benefit Period begins on your coverage date. The last Benefit Period ends when you are no longer covered.

Birthing Center – a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

- **a)** provide full-time Skilled Nursing Care by or under the supervision of Nurses;
- **b)** be staffed and equipped to give Medical Emergency care; and
- **c)** have written back-up arrangements with a local Hospital for Medical Emergency care.

The Plan will recognize it if:

- **a)** it carries out its stated purpose under all relevant state and local laws; or
- **b)** it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
- **c)** it is approved for its stated purpose by Medicare.

The Plan does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Blue Card Provider – a Provider not in New Jersey which has a written agreement with another Blue Cross and Blue Shield company to provide care to both that company's Subscribers and other Blue Cross and Blue Shield companies' Subscribers. For purposes of this booklet, a Blue Card Provider is an In-Network Provider.

Care Manager – a person or entity designated by the Plan to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment members. Your doctor is given a certification number after this approval is given.

Certification/Pre-approval – authorization by the Plan for a doctor to provide specified treatment to anesthesia, who is employed by and under the supervision of a Physician anesthesiologist.

Certified Registered Nurse Anesthetist (C.R.N.A.) – A Registered Nurse, certified to administer

Chemotherapy – treatment of malignant disease by chemical or biological antineoplastic agents.

Co-insurance – The percentage applied to the allowance for certain covered services and supplies in order to calculate benefits under the Plan.

Cosmetic – Services rendered to refine or reshape body structures or surfaces that are not functionally impaired. They are to improve appearance or self-esteem, or for other psychological, psychiatric or emotional reasons.

Covered Services and Supplies – the types of services and supplies described in the Covered Services and Supplies section of this booklet. The services and supplies must be:

- **a)** furnished or ordered by a Provider; and
- **b)** Medically Necessary and Appropriate to diagnose or treat an Illness, Accidental Injury, Mental or Nervous Conditions.

Creditable Coverage – your prior coverage under any of the following: a group health plan; a group or individual health benefits plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal Social Security Act (the program for distribution of pediatric vaccines); chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services and their dependents); a medical care program of the Indian Health Service or of a tribal organization; a State health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code; a public health plan as defined by federal regulation; or a health benefits plan under section 5(e) of the "Peace Corps Act".

Creditable Coverage does not include coverage which consists solely of the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance; coverage for on-site medical clinics; coverage as specified in federal regulation, under which benefits for medical care are secondary or incidental to the insurance benefits; and other coverage expressly excluded from the definition of health benefits plan as defined in C. 17B:27A-19, et seq.

Deductible – The amount of covered medical expenses that you must incur and pay for before you are eligible to receive benefits under your program.

Detoxification Facility – A health care facility licensed by the State of New Jersey as a Detoxification Facility for the treatment of alcoholism, or one which meets the same standards if located in another state.

Durable Medical Equipment – equipment which the Plan determines to be:

- **a)** designed and able to withstand repeated use;
- **b)** primarily and customarily used to serve a medical purpose;
- **c)** generally not useful to you in the absence of an Illness or injury; and
- **d)** suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Experimental or Investigational – any treatment, procedure, Facility, equipment, drug, device, or supply eligible (collectively "technology") which, as Determined by the Plan, fails to satisfy the following criteria:

With respect to items requiring government approval (e.g., drugs, biological products and devices), the technology must have final approval from the appropriate government regulatory bodies for commercial distribution for use in the treatment of the condition under review. However, the Plan will not exclude as Experimental/Investigational a Prescription Drug for a treatment for which it has not been approved by the Food and Drug administration; and will provide coverage for such to the same extent as other Prescription Drugs if the drug is recognized as being Medically Necessary and Appropriate for the specific treatment for which it has been prescribed in one of the following compendia:

- the American Medical Association Drug Evaluations;
- the American Hospital Formulary Service Drug Information;
- the United States Pharmacopoeia Drug Information; or
- it is recommended by a clinical study or review article in a major-peer reviewed professional journal.

Note: No coverage will be provided for Prescription Drugs for any Experimental or Investigational drug or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

a) With respect to items not requiring governmental approval, scientific evidence, including peer literature, must exist which demonstrates, as determined by the Plan, that the technology improves net health outcomes; and

b) The technology must be as beneficial as any established alternatives; and

c) The improvement in net health outcome must be attainable under the usual conditions of medical practice.

Facility – An entity or institution which provides health care services within the scope of its license as defined by applicable law, which the Plan:

a) is required by law to recognize; or

b) determines, in its sole discretion, to be eligible.

Group Health Plan – an Employee welfare benefit plan, as defined in Section 3 of Title I of ERISA to the extent that the Plan provides medical care and includes items and services paid for as medical care to Employees or their dependents directly or through insurance, reimbursement or otherwise.

Home Health Agency – a Provider which mainly provides Skilled Nursing Care for an Ill or Injured person in his home under a home health care program designed to eliminate Hospital stays. The Plan will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospital – a Facility which mainly provides inpatient care for Ill or Injured people. The Plan will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

- **a)** accredited as a Hospital by the Joint Commission or
- **b)** approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, infirmary, Hospice, Substance Abuse Center or a Facility, or part of it, which mainly provides domiciliary or Custodial Care, educational care, non-medical or rehabilitative care. A Facility for the aged is also not a Hospital.

The Plan will pay benefits for covered medical expenses incurred at hospitals operated by the United States government only if services are for treatment on an emergency basis; or services are provided in a hospital located outside of the United States.

The above limitations do not apply to military retirees, their dependents, and the dependents of active-duty military personnel who: (i) have both military health coverage and the Plan coverage; and (ii) receive care in facilities run by the Department of Defense or Veteran's Administration.

In-Network – a Provider, or the Covered Services and Supplies provided by a Provider, who has an agreement with the Plan to furnish Covered Services or Supplies.

Medically Necessary and Appropriate – a Covered Service or Supply that the Plan determines is:

- **a)** necessary for the symptoms and diagnosis or treatment of the condition, Illness or injury;
- **b)** provided for the diagnosis, or the direct care and treatment, of the condition, Illness or injury;
- **c)** in accordance with generally accepted medical practice;
- **d)** not for your convenience;
- **e)** the most appropriate level of medical care you need;

f) accepted by a professional medical society in the United States as beneficial

g) **f**or the control or cure of the Illness or injury being treated; and furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the service or supply or the length of time services or supplies are to be received, does not make the services or supplies Medically Necessary and Appropriate.

Network – the Direct Access Provider Network.

Out-of-Network – a Provider, or the services and supplies provided by a Provider, who does not have an agreement with the Plan to provide Covered Services or Supplies.

Practitioner – includes but is not limited to the following: physicians, chiropractors, dentists, optometrists, pharmacists, chiropodists, psychologists, physical therapists, audiologists, speech language pathologists, certified nurse-midwives, registered professional nurses, nurse practitioners and clinical nurse specialists.

Rehabilitation Center – a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. The Plan will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
approved for its stated purpose by Medicare.

Skilled Nursing Facility – a Facility which mainly provides full-time Skilled Nursing Care for ill or injured people who do not need to be in a Hospital. The Plan will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited for its stated purpose by the Joint Commission; or

b) approved for its stated purpose by Medicare. In some places, a Skilled Nursing Facility may be called an "Extended Care Center" or a "Skilled Nursing Center."

Substance Abuse – the abuse or addiction to drugs or controlled substances, not including alcohol.

Therapeutic Manipulation – the treatment of the articulations of the spine

and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive therapy, ultra-sound, Doppler, whirlpool or hydro-therapy or other treatment of a similar nature.

Therapy Services – the following services and supplies are covered when they are:

a) ordered by a practitioner;

b) performed by a provider;

c) for a patient who is a Hospital inpatient or outpatient or a recipient of covered Home Health Agency;

d) Medically Necessary and Appropriate for the treatment of your Illness or Accidental Injury.

- **Chelation Therapy** – administration of drugs or chemicals to remove toxic concentrations of metals from the body.
- **Chemotherapy** – treatment of malignant disease by chemical or biological antineoplastic agents.
- **Cognitive Rehabilitation Therapy** – retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.
- **Dialysis Treatment** – treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
- **Infusion Therapy** – administration of antibiotic, nutrient, or other therapeutic agents by direct infusion.
- **Occupational Therapy** – treatment to restore a physically disabled person’s ability to perform the ordinary tasks of daily living
- **Physical Therapy** – treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Accidental Injury or loss of limb.
- **Radiation Therapy** – treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.
- **Respiration Therapy** – introduction of dry or moist gases into the lungs.

Speech Therapy – treatment for the correction of a speech impairment resulting from Illness, Surgery, Accidental Injury, congenital anomaly, or previous therapeutic processes.

Urgent Care Claim - An Urgent Care Claim is any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations:

a) Could 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, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claims.

Urgent Care – Out-patient or Out-of-Hospital medical care which, as Determined by Horizon BCBSNJ or condition that is not life threatening, but should be treated by a provider within 24 hours.