SCHEDULE A

POINT OF SERVICE (POS) MEDICAL BENEFIT

NOE-ILA, AFL-CIO WELFARE PLAN
FOR NON-MEDICARE ELIGIBLE RETIREES & DEPENDENTS
Effective: October 1, 2010

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MEDICAL BENEFIT:

Designated Network.....MultiPlan PHCS Network

Designated Utilization Reviewer.....American Health Holding

Required Monthly Self-Payment Amounts

Individual coverage: $43 per month

Family coverage: $84 per month

Lifetime Maximum Benefit $250,000*

Deductible ..... None

Out-of-Pocket Maximum Limit ..... $5,000 per Participant per calendar year
$10,000 per family per calendar year

Office Visits ..... 100% after $15 per visit Co-Pay

Preventive and Wellness Benefit ..... 100% up to a maximum of $200 per Participant per calendar year

Surgery (other than in Physician's office when it is covered at level described under Office Visits) 90%

Physician Hospital Services 90%

Diagnostic X-ray & Laboratory (other than Physician's office or routine tests) 90%

Hospital Services

Inpatient coverage ..... 90% after $375 per confinement Co-Pay

Outpatient coverage ..... 90% after $100 per treatment Co-Pay

*Lifetime Maximum Benefit includes Mental Health Benefit but excludes outpatient Prescription Drug Benefit.

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MEDICAL BENEFIT (continued):

Emergency Room..... 90% after $50 per emergency room visit Co-Pay (waived if admitted to Hospital)

Pre-Certification Required For Non-Emergency Hospital Admissions & Non-Emergency Outpatient Surgical Procedures, And Notification Required Within 48 Hours Of Emergency Hospital Admissions & Emergency Outpatient Surgical Procedures.

For required pre-certification and required notification for Hospital admissions and outpatient surgical procedures, call American Health Holding at 866-353-6507 to initiate the process.

Penalty For Failure To Pre-Certify Or Notify Within 48 Hours As Required:

For Hospital admissions..... benefits otherwise payable will be reduced by $250 per day of Hospitalization

For Outpatient Surgical Procedures..... benefits otherwise payable will be reduced by $250

Non-emergency use of an Emergency Room ..... Not covered

Skilled Nursing Facility ..... 90% up to 60 days per Participant per calendar year;

Home Health Care..... 90% up to 75 visits per Participant per calendar year

Hospice Care Benefit (for terminally ill patients)..... Combined maximum benefit of $5,000 for both inpatient and outpatient coverage

Inpatient coverage..... 90% of Allowable Charge
Outpatient coverage ..... 100% of Allowable Charge

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MEDICAL BENEFIT (continued):

Counseling for immediate family within six months of Participant's death ..... 100% (Maximum of 20 visits limited to $40 per visit)

Ambulance 90%

Durable Medical Equipment 90%

Maternity ..... Payable as any other covered expense

Chiropractic services ..... 20 visits per Participant per calendar year, limited to $30 per visit

PRESCRIPTION DRUG BENEFIT:

Network Pharmacy and Network Administrator ..... CAREMARK

This means that any CAREMARK pharmacy is a "Network Pharmacy" and that CAREMARK is the Network Administrator for the Prescription Drug Benefit. Participants may contact CAREMARK as follows:

- Call a CAREMARK customer service representative, available 24 hours a day, seven days a week, at: 1-866-875-6452 toll-free, or 1-800-231-4403 for TDD Users; or

- Use the interactive voice response system, using the same telephone numbers listed above, to refill an order or check the status of an order, also available 24 hours a day, seven days a week; or

- Visit CAREMARK's website at www.caremark.com to fill prescriptions or to check prescription history, shipping status or drug pricing.

The Mail Service Network Pharmacy and contact information is as follows:

CAREMARK Mail Service Pharmacy
P.O. Box 3223
Wilkes-Barre, PA 18773-3223

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PRESCRIPTION DRUG BENEFIT (continued):

	Network Pharmacy	Out-of-Network Pharmacy
Brand Name Prescription Drug Deductible per Family	$500 calendar year deductible per family applies to all Brand Name Prescription Drugs when a generic equivalent is available	
Prescription Drugs Retail (30-day supply)	**Co-Payments**	
Generic Drug	$5	$5
Preferred Brand Name Drug	$10	$10
Non-Preferred Brand Name Drug	$25	$25 Plus excess over Network contract rate
Prescription Drugs Mail Order (90-day supply)*	**Co-Payments**	
Generic Drug	$5	Not Covered
Preferred Brand Name Drug	$15	Not Covered
Non-Preferred Brand Name Drug	$50	Not Covered

*90-day supply is available at CVS Pharmacies for the 90-day Co-payments described above.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT:

Coverage provided *Only* for Network Providers. No benefits are payable for Out-Of-Network Providers.

Designated Network, Network Manager & Patient Care Coordinator..... Magellan Health Services

Contact Information for Network, Network Manager & Patient Care Coordinator:

Magellan Health Services
14100 Magellan Plaza
Maryland Heights, MO 63043
Telephone Number: 1-800-584-7459

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MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT (continued):

Pre-Certification Required As Condition Of Coverage:

The Patient Care Coordinator *Must* Be Contacted Before Receiving Treatment for Referral to a Network Provider. **Effective January 1, 2013, pre-certification is no longer required as a condition of coverage for outpatient procedures but continues to be required as a condition of coverage for inpatient procedures.**

Penalty For Failure To Pre-Certify When Required: ..... No Coverage

Lifetime Maximum Benefit for Mental Health Combined with Lifetime Maximum Benefit for Medical Benefit $250,000

Lifetime Maximum Benefit for Substance Abuse only (Inpatient and Outpatient Combined) per Participant (in addition to Lifetime Maximum Benefit for Mental Health combined with Medical Benefit) $25,000

Calendar Year Maximum for Substance Abuse only (Inpatient and Outpatient Combined) per Participant $20,000

Outpatient Calendar Year Deductible per Participant $250

Hospital Deductible per Participant ..... $250 plus $50 per day for 1st 5 days of hospitalization (maximum $500 deductible)

Co-Insurance (after deductible) payable by Plan for Eligible Charges incurred during calendar year until satisfaction of Family Out-of-Pocket Maximum..... 80%

Co-Insurance (after deductible) payable by Plan for Eligible Charges incurred during calendar year after satisfaction of Family Out-of-Pocket Maximum, up to Calendar Year and Lifetime Maximum Benefits..... 100%

Family Out-of-Pocket Maximum Per Calendar Year $1,500

ARTICLE I
POINT OF SERVICE (POS) MEDICAL BENEFIT

Section 1.1 – Eligibility, Scope Of Coverage And Required Use Of Network Providers

Only those Retired Employees and their Dependents who qualify for the POS Medical Benefit, enroll timely and pay the required monthly self-payment, as provided in Section 5.1(a) of the Welfare Plan, are covered for the POS Medical Benefit.

The POS Medical Benefit covers Eligible Charges incurred for medical care furnished by Network Providers, to the extent described in this Schedule A. No benefits are provided for medical care furnished by Out-of-Network Providers. This benefit is self-insured by the Fund. An expense is incurred on the date the service or supply for which it is charged is furnished.

The Network designated by the Trustees and all contact information are set forth in the Schedule of Benefits. The Trustees may change the Network from time to time. Participants will be notified of any such changes.

Section 1.2 – Enrollment And Disenrollment In The POS Medical Benefit

Each Retired Employee and Dependent who is eligible and wants to participate in the POS Medical Benefit must enroll. Enrollment is a two-step process. An enrollment form must be completed by the Retired Employee for himself or herself and for all covered Dependents. All completed enrollment forms must be returned to the Fund Office or a Field Office.

A Network Provider directory will be provided to Participants upon enrollment in the POS Medical Benefit and at any time thereafter upon a Participant's written request to the Fund Office or a Field Office (free of charge).

Participants may disenroll from the POS Medical Benefit by giving written notice of disenrollment to the Fund Office or a Field Office. Once a Participant disenrolls, all coverage for the Participant under the POS Medical Benefit will end as of the end of the month for which the last required self-payment is made, with no right to re-enroll in the POS Medical Benefit.

Section 1.3 – Self-Payment Required For Participation In POS Medical Benefit

The POS Medical Benefit is "contributory", which means that a Participant who is eligible and wishes to enroll in the POS Medical Benefit must pay the required monthly self-payment in order to be covered. The Trustees have the discretionary authority to establish the amount of the required self-payment and to change it from time to time. The amount of the required monthly self-payment is described in the Schedule of Benefits. Participants will be notified of any changes.

As a convenience, Retired Employees who participate in the POS Medical Benefit have the option to direct that the monthly self-payment be deducted from their monthly pension check payable from the Pension Plan. To elect this option, a Retired Employee must complete a

written authorization form directing the Pension Plan to deduct the monthly self-payment amount from each monthly pension check and pay it to the Welfare Plan on his or her behalf. This payment method and authorization is strictly voluntary and may be revoked by the Participant at any time by written notice to the Fund Office. A written revocation will be implemented beginning with the first day of the month that is at least 30 days after receipt of the revocation by the Fund Office.

Section 1.4 – How To Obtain Network Benefits

In order to receive covered medical care under the POS Medical Benefit, a Participant must first arrange for an appointment with a Network Provider. The Participant must present his or her ID card to the Network Provider at the time of the visit, and pay any required Co-Pay and remaining amount owed if the Co-Insurance percentage payable under the POS Medical Benefit is less than 100% (refer to the Schedule of Benefits).

For example, if a Participant receives Physician Hospital Services, the Co-Insurance percentage payable under the POS Medical Benefit is 90%, which means that 90% of the Eligible Charges will be paid directly by the Welfare Plan to the Network Provider and the remaining 10% is payable by the Participant. There are no claim forms to complete, and no waiting for reimbursement checks.

Section 1.5 – What Is Covered and What Is Excluded By the POS Medical Benefit

(a) **Coverage in General**:

The POS Medical Benefit pays the applicable Co-Insurance percentage of the Eligible Charges incurred by a Participant depending upon the category of medical services and equipment received, subject to the Lifetime Maximum Benefit and any other exclusions and limitations that apply, as described in the Schedule of Benefits and this Schedule A.

(b) **Co-Pay, Co-Insurance and Out-of-Pocket Limit**:

The following terms, when used in this Schedule A, have the meaning set forth below:

(i) "Co-Pay" means a flat dollar amount payable by a Participant per visit, per confinement, or per procedure, as listed in the Schedule of Benefits;

(ii) "Co-Insurance" means the percentage of Eligible Charges payable by the POS Medical Benefit, as listed in the Schedule of Benefits for certain categories of services. If the Co-Insurance percentage payable by the POS Medical Benefit is less than 100%, the remaining Eligible Charges are payable by the Participant.

(iii) "Out-of-Pocket Maximum" means the maximum amount of Eligible Charges that a Participant or family is responsible for paying during a calendar year, before the Co-Insurance percentage payable under the POS Medical Benefit for the Participant or family (as applicable), increases to 100% for Eligible Charges incurred during the remainder of the calendar year.

Any change to a Co-Pay, Co-Insurance, or Out-of-Pocket Maximum, will be reflected in an amended Schedule of Benefits adopted by the Trustees, and Participants will be notified of the change.

(c) Lifetime Maximum Benefit:

The Lifetime Maximum Benefit is the maximum amount payable under the POS Medical Benefit for each Participant during his or her lifetime, as shown in the Schedule of Benefits. Once a Participant reaches the Lifetime Maximum Benefit, no further benefits are payable by the POS Medical Benefit for that Participant.

(d) Mental Health and Substance Abuse Treatment:

Mental health and substance abuse treatment is covered to the extent described in Article III.

(e) No Coverage for Weekend Hospital Admissions Except For Medical Emergencies:

The POS Medical Benefit does not cover any charges incurred for medical treatment received in connection with a Hospital admission on Saturday or Sunday unless it is for a medical emergency procedure.

(f) Outpatient Surgery Benefit:

Eligible Charges incurred for outpatient surgery performed at an outpatient surgical facility are covered by the POS Medical Benefit at the applicable Co-Insurance level, as reflected in the Schedule of Benefits, but only if the following requirements are satisfied:

(1) The outpatient surgical facility must be a Network Provider that is approved by the appropriate State regulatory authority (it may be either free-standing or part of a Hospital facility); and

(2) The outpatient surgical facility must be capable of handling surgical cases on a "same day" basis; have a staff of Physicians and continuous Physician and registered nursing (R.N.) care when patients are present; and be used mainly for performing outpatient surgery.

If an outpatient surgery is covered in accordance with the above requirements, Eligible Charges related to the outpatient surgery and incurred for medical supplies, drugs, medications, laboratory services and Physicians' services will also be covered provided they would have been covered had the surgery been performed on an inpatient basis in a Hospital that is a Network Provider. If the outpatient surgery is performed in a Physician's office, Eligible Charges incurred for the related items listed will be payable

at the Co-Insurance level payable for Office Visits, subject to an office visit Co-Pay as shown in the Schedule of Benefits, but only if an office visit is charge by the Physician.

(g) Pre-Admission Testing for Hospital Admission:

Eligible Charges incurred for medical tests and studies performed on an outpatient basis prior to a scheduled Hospital admission of a Participant for surgery, when required for admission and rendered or accepted by the Hospital, is covered at the applicable Co-Insurance level reflected in the Schedule of Benefits without application of an outpatient coverage co-pay, provided the services would have been available to patients admitted to the Hospital. Pre-admission testing does not include medical tests and studies performed to establish a medical diagnosis.

(h) Home Health Care Benefit:

Eligible Charges incurred for Home Health Care provided by a Network Provider is covered at the Co-Insurance level and subject to the limits described in the Schedule of Benefits.

For coverage purposes, "Home Health Care" means medical care that is arranged through a Home Health Agency or Hospital and furnished to a Participant at home.

"Home Health Agency" means an agency that is licensed to provide Home Health Care under Medicare.

"Home Health Aide" means a person who provides services for patient care and is appropriately trained for Home Health Care under the supervision of a registered nurse employed by the Home Health Agency.

In order for charges for Home Health Care to be covered, the following requirements must be satisfied:

(1) A Home Health Care treatment plan, prescribing the plan for continued treatment and including an estimated duration, must be submitted in writing by a Physician. The Physician must recertify, as applicable, the need for continued Home Health Care upon request by the Utilization Reviewer; and

(2) The Home Health Care must be needed by the Participant in place of being in a Hospital or Skilled Nursing Facility; and

(3) The treatment must be a curing aid that is necessary for treatment of a bodily injury or sickness, and not palliative care.

The following Home Health Care services are covered under the Home Health Care benefit:

(1) Services on a part-time or intermittent basis by a registered nurse, licensed practical nurse or Home Health Aide;

(2) Services performed by a licensed physical, occupational, speech and/or respiratory therapist; and

(3) Medical support services and supplies, such as drugs and medicines, when prescribed by the Physician, as well as laboratory services and other supplies that would have been covered if the Participant had remained in the Hospital or a Skilled Nursing Facility.

Up to 4 hours of Home Health Care will count as 1 visit.

Charges incurred for any of the following are excluded from coverage:

(1) Services provided during any period in which the patient is not under the care of his or her Physician;

(2) Services or supplies not included in the Home Health Care treatment plan;

(3) Food, housing, homemaker services and home-delivered meals;

(4) Services provided by a person who ordinarily resides in the patient's home or is a member of the patient's family; and

(5) Services provided by an Out-of-Network Provider.

(i) <u>Hospice Care Benefit:</u>

Eligible Charges incurred for Hospice Care provided by a Network Provider are covered at the Co-Insurance level and subject to the limits described in the Schedule of Benefits. "Hospice Care", for coverage purposes, is defined as care for a Participant who is terminally ill, which means the Participant's life expectancy is six months or less as certified by a Physician. Hospice Care is a coordinated program of home and inpatient care, for a terminally ill patient and the patient's immediate family, provided by a hospice care agency. "Immediate family", for purposes of the Hospice Care Benefit, means the Retired Employee and any eligible Dependent.

The Hospice Care Benefit covers the following Hospice Care services and types of medical charges, subject to the conditions and limits described above and in the Schedule of Benefits:

(1) Room and board charged by the Hospice Care agency;

(2) Special charges and supplies;

(3) Part-time nursing care by or supervised by a registered nurse (RN);

(4) Home Health Care services as described under the Home Health Care Benefit, except that the number of visits is not limited and prior Hospital confinement is not required;

(5) Counseling for the patient and the patient's immediate family by a licensed social worker or licensed pastoral counselor; and

(6) Bereavement counseling for the patient's immediate family by a licensed social worker or licensed pastoral counselor within six (6) months after the patient's death.

Hospice Care services for the patient must be given in an inpatient hospice facility.

(j) Skilled Nursing Facility Benefit:

For purposes of this benefit, a "Skilled Nursing Facility" is a facility that is mainly engaged in providing skilled nursing care and other therapeutic services. The Skilled Nursing Facility must be licensed by the State in which it is located and must be an eligible provider of Medicare and Medicaid nursing care services.

The Skilled Nursing Facility Benefit covers Eligible Charges incurred by a Participant for the first 60 days of confinement in a Skilled Nursing Facility each calendar year, payable at the Co-Insurance level described in the Schedule of Benefits, provided the following requirements are satisfied:

(1) The Participant's Physician prescribes a written treatment plan for the Participant, while confined in the Skilled Nursing Facility, and supervises such care and treatment; and

(2) The Skilled Nursing Facility maintains the written treatment plan, in addition to medical records, for the Participant and each other patient while confined in the facility; and

(3) The skilled nursing care and other therapeutic services rendered in the Skilled Nursing Facility are for the same injury or sickness that caused the Hospital confinement from which transfer to the Skilled Nursing Facility is being made; and

(4) In the absence of such skilled nursing care, the Participant would be required to be an inpatient at a Hospital.

Coverage for the room and board charges by a Skilled Nursing Facility is limited to fifty percent (50%) of the room and board charges for a semi-private room in the Hospital where the Participant was or would otherwise be confined.

(k) Utilization Management:

To help hold down health care costs, the POS Medical Benefit has a utilization management program that requires Hospital precertification and participation in case management services as a condition of coverage. There is a "Utilization Reviewer" (UR) appointed by the Trustees to manage the utilization management program for the POS Medical Benefit. The name of the UR and contact information are set forth in the Schedule of Benefits. Participants will be notified of any changes in the utilization management program or UR.

(l) Hospital Admissions and Outpatient Surgical Procedures - Pre-Certification Required If Non-Emergency and 48-HourNotification Required If Emergency, With Penalty For Failure to Comply:

Hospital Pre-Certification is the process used to pre-certify, for coverage purposes, the Medical Necessity and length of Hospital confinement for a Participant's non-emergency medical care and non-emergency outpatient surgical procedure. Hospital Pre-Certification is required for all non-emergency Hospital admissions, whether on an inpatient basis or for an outpatient surgical procedure.

Once a Participant is admitted to a Hospital, the Utilization Reviewer (UR) will continue to monitor the length of stay to help assure that the admission continues to be Medically Necessary and will provide discharge planning, if and as needed, for Home Health Care and for medical equipment that may be needed during recovery.

Participants are responsible for satisfying the Hospital Pre-Certification requirements by contacting the UR as described in the Schedule of Benefits, prior to a non-emergency Hospital admission or surgical procedure, to initiate the process. If it is an emergency Hospital admission or surgical procedure, the Participant must contact the UR within 48 hours following the admission or procedure. Participants will be notified of any changes in the UR or contact information. The Physician or a family member may also initiate the required Hospital Pre-Certification, or satisfy the required notification following an emergency Hospital admission or surgical procedure, on behalf of the Participant by contacting the UR.

There is a penalty for failure to comply with these requirements as described in the Schedule of Benefits.

(m) Case Management:

Case Management applies when a serious medical condition indicates that a Participant may need long term care. Under the Utilization Management program, the UR will designate a case manager and/or Physician to assist the Participant's own Physician in identifying, if and as appropriate, other treatment settings and levels of care and to coordinate the long term care needs of the Participant by working with the Participant, the family members and members of the medical team.

(n) Coverage In Emergency Situations and For Use of Emergency Room:

In an emergency situation, a Participant should use reasonable efforts to contact his or her Physician before seeking medical attention, since the Physician knows the Participant's medical history and is responsible for coordinating the Participant's care. However, if that is not possible or if the Physician cannot be reached, the Participant should seek more immediate medical help. The Physician should be notified as soon as possible even if it is after the Participant has received emergency care.

If a Participant has a medical emergency that necessitates going to the emergency room, the Utilization Reviewer must be contacted by telephone for certification purposes, by the Participant or the Participant's Physician, within 48 hours after the emergency room visit.

A "medical emergency" generally means a sudden and unexpected change in a Participant's physical or mental condition that is severe enough to require Hospital-level care. Some examples of medical emergencies include a heart attack, poisoning, severe bleeding and loss of consciousness. Medical emergencies do not include minor cuts and sprains, sore throats, colds and flu.

The POS Medical Benefit does not cover use of an emergency room for something that is not a medical emergency, even if the Participant is out of town. If a Participant is out of town and experiences an urgent medical problem that is not a medical emergency, the Participant should contact his or her Physician for authorization for medical treatment or other instructions. In no event will coverage be provided for an emergency room visit for an urgent medical problem that is not a medical emergency, even if the Participant is out of town.

(o) Preventive and Wellness Benefit:

The Preventive and Wellness Benefit covers 100% of the Reasonable and Customary Charges incurred by a Participant while covered by the POS Medical Benefit, up to the maximum listed in the Schedule of Benefits, for Physician examinations and any of the following services:

Cholesterol Tests
Complete Blood Count
Diagnostic X-Ray
Electrocardiogram
Fecal Blood Tests
Gynecological Examination
Immunizations
Mammograms
Occult Blood Count
Pap Smear
Pelvic Exams
Physical Examinations
Prostate Testing
Sigmoidoscopies
Stress Testing – Maternity
Stress Tests
Urinalysis

(p) Other Medical Charges Covered Under the POS Medical Benefit:

In addition to the specific benefits described above, Eligible Charges incurred by a Participant for any of the following, when prescribed by the attending Physician for injury, illness or maternity care, are covered subject to the limits set forth in the Schedule of Benefits and also to the Network Provider requirements:

(1) Hospital charges for room and board, with the daily allowance not to exceed the average semi-private room rate charged by the Hospital; however, the full charge for an intensive care unit will be considered eligible;

(2) Other Hospital charges incurred by a Participant, on an inpatient or outpatient basis, for use of the operating room, delivery room, treatment room, recovery room, emergency room, outpatient department or free-standing surgical center, as well as for any of the following: prescription drugs, anesthesia materials and administration of anesthesia by licensed personnel; laboratory examinations; oxygen and its administration; medical and surgical supplies; drugs and medicines approved by the Food and Drug Administration or its successor and provided to a Participant while confined in the Hospital or outpatient surgical facility; blood, blood plasma, blood derivatives and blood processing; transfusion fees and equipment; electrocardiograms; x-ray, nuclear medicine, sonography, computerized tomography, and magnetic resonance imagery; physical therapy; intravenous injections and solutions; electroencephalograms; traction; use of an intensive care unit, cardiac unit or burn unit when such units are approved; heart laboratory, cardiovascular laboratory and vascular laboratory; chemotherapy and radioisotope therapy including use of materials such as nitrogen mustard, radioactive gold and radioactive iodine; radiation therapy and high intensity x-ray therapy, including electrically produced therapy and radioactive materials such as cobalt, radium and radium implant; and hemodialysis expenses related to

laboratory tests and consumable and expendable supplies such as dialysis membrane, dialysis solution, tubing and drugs required during dialysis;

(3) Physician's services for any of the following: surgery; home, office and Hospital visits; examination, diagnosis, consultation and evaluation; and other medical care and treatment;

(4) Medical services of a Physician or Dentist for dental care and treatment, dental surgery, dental appliances and replacement of natural healthy teeth, but only in the following cases: the surgical removal of impacted wisdom teeth; and services directly related to an accidental bodily injury sustained while the Participant is covered under the POS Medical Benefit and rendered during the 24 months immediately following such injury, provided the treatment giving rise to such charges begins within 90 days after such injury;

(5) Chiropractic services subject to the limits set forth in the Schedule of Benefits, and x-rays, casts, splints and braces if they are consistent with the diagnosis;

(6) Physical, occupational, speech, visual and audio therapy when prescribed by a Physician or registered therapist who is not a member of the Participant's immediate family (defined as the Retired Employee's spouse, and the children, brothers, sisters and parents of the Retired Employee or his or her spouse);

(7) Private duty nursing when prescribed by a Physician and provided by a registered nurse or licensed practical nurse who is not a member of the Participant's immediate family (defined as the Retired Employee's spouse, and the children, brothers, sisters and parents of the Retired Employee or his or her spouse), subject to any applicable limits under the Home Health Care Benefit and Hospice Care Benefit;

(8) Casts, splints, crutches, surgical dressings and artificial limbs and eyes;

(9) Rental of basic wheelchairs, Hospital beds and durable medical and surgical equipment for the treatment of a bodily injury or sickness which (a) can withstand repeated use; and (b) is primarily and customarily used to serve a medical purpose; and (c) is not generally useful to a person except in the treatment of a bodily injury or sickness, subject to the limit set forth in the Schedule of Benefits;

(10) Artificial prosthetic devices that replace a natural part of the body except for an artificial heart. Loss of the natural body part must occur while the Participant is covered under the POS Medical Benefit, and replacements are limited to two per year;

(11) Transportation by professional ambulance to or from a local Hospital, or if special treatment is required which is not available in a local Hospital, transportation by professional ambulance, railroad or a regularly scheduled

commercial passenger flight to or from the nearest Hospital equipped to furnish such special treatment;

(12) Outpatient diagnostic x-ray and microscopic or laboratory tests;

(13) Prescription Drugs and medicines prescribed by a Physician for use following a Participant's discharge from a Hospital or outpatient surgical facility, other than those covered by the Prescription Drug Benefit. Prescription Drugs prescribed for use in a Hospital or outpatient surgical facility are covered as other Hospital expenses. In order to be covered as described, the Prescription Drugs must be approved by the Food and Drug Administration or its successor and do not include over-the-counter drugs or drugs available without a prescription, even if a Physician has prescribed them in writing;

(14) Medical care and services for or related to pregnancy including childbirth, miscarriage, abortion and any complications resulting from pregnancy, provided that such coverage is provided for or related to the pregnancy of a Retired Employee or Dependent spouse only, and not of a Dependent child; and

(15) Removal of mammary implant(s) that were surgically implanted, but only if a preoperative report from a Physician specializing in the field indicates that removal of the implant(s) is Medically Necessary. If removal is not specifically recommended as Medically Necessary, coverage (although denied on the basis of the pre-operative reports) will again be considered after surgery when Hospital records, an operative report and pathology reports are available and provided to the Utilization Reviewer.

(q) <u>Exclusions and Limitations Under The POS Medical Benefit:</u>

Notwithstanding any other provision in this Schedule A to the contrary, charges incurred for any of the following are excluded from coverage and will not be payable under the POS Medical Benefit:

(1) Dental work (except when Hospital confined), dental diagnosis and treatment, eye examinations, eye glasses, contact lenses, special eye glasses and/or contact lenses required as a result of a cataract operation, hearing aids, and cosmetic surgery, except to the extent specifically covered in connection with services directly related to an accidental bodily injury sustained while covered under the POS Medical Benefit and rendered during the 24-month period immediately following such injury, provided the treatment giving rise to such charges begins within 90 days after such injury;

(2) Charges for mental and emotional illness or substance abuse, except as specifically covered under the Mental Health and Substance Abuse Benefit described in Article III;

(3) Bodily injury or sickness resulting from war or any act incident to war, whether the war is declared or undeclared;

(4) Injury which arises out of or in the course of employment, or sickness for which benefits are payable under a Workers' Compensation Act or similar legislation;

(5) Health or check-up examinations other than those necessary for the treatment of a bodily injury or sickness, except to the extent covered under the Preventive and Wellness Benefit;

(6) Charges incurred for artificially induced pregnancy or for the diagnosis and treatment of fertility or infertility, including but not limited to artificial insemination, in-vitro fertilization, embryo placement and/or gamete intra-fallopian tube transfer, low tubal ovum transfer which involves a Participant or surrogate as a donor or recipient, any drug or hormonal therapy administered as part of the treatment, and any experimental preparatory services or other form of artificially induced pregnancy;

(7) Any bodily injury or sickness caused by, or as a result of, the commission of a felony or attempt to commit a felony, by a Participant. In the event the Participant is arrested, charged with, or indicted for a felony or attempted felony, any and all payments that may be due under the POS Medical Benefit will not be payable until a final judicial determination has been made;

(8) Charges which are in excess of Reasonable and Customary Charges;

(9) Charges which a Participant is not legally required to pay;

(10) Eye surgery, including but not limited to radial keratotomy, when the primary purpose is to correct myopia (near-sightedness), hyperopia (farsightedness) or astigmatism (blurring);

(11) Charges for a Physician's service or x-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process or the gums, even if a condition requiring any of these services involves a part of the body other than the mouth, such as the treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring or repositioning teeth. This exclusion does not apply to charges made for treatment or removal of a malignant tumor;

(12) Charges for services or supplies, including tests and check-up examinations, that are not "needed" for medical care of a diagnosed bodily injury or sickness, except to the extent covered under the Preventive and Wellness Benefit. To be considered "needed", a service or supply must meet all of the following requirements:

(i) It must be ordered by a Physician;

(ii) It must be commonly and customarily recognized throughout the Physician's profession as appropriate in the treatment and diagnosis of the bodily injury or sickness;

(iii) It is not educational or experimental in nature, and for coverage purposes, investigational procedures are considered experimental; and

(iv) It is not furnished mainly for the purpose of medical or other research.

In the case of a Hospital confinement and for coverage purposes, the length of the confinement and the Hospital services and supplies are "needed" only to the extent they are determined to be:

(i) Related to the treatment of the bodily injury or sickness; and

(ii) Not for the scholastic education or vocational training of the patient;

(13) Expenses for treatments, procedures, devices, and drugs which the Trustees or their designee, in the exercise of their discretion, determine are experimental, investigational or done primarily for research, unless all of the following conditions are satisfied:

(i) Approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and

(ii) "Reliable evidence" shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy compared with the standard means of treatment or diagnosis; and

(iii) "Reliable evidence" shows that the consensus of opinion among experts regarding the treatment, procedure, device or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy compared with the standard means of treatment or diagnoses.

"Reliable evidence", for purposes of this exclusion, includes anything determined to be such by the Trustees or their designee, in the exercise of their discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community;

(14) Charges or expenses for or incident to intersex surgery or any treatment to alter physical characteristics to those of the opposite sex, including any complications resulting from such surgery or treatment;

(15) Charges for treatment of sexual dysfunction or sexual inadequacies unless the treatment is required as a result of another physical illness. This includes but is not limited to penile implants and prostheses;

(16) Charges or expenses for orthoptics or visual training;

(17) Charges or expenses for weight control or obesity, unless incurred for the treatment of morbid obesity. "Morbid obesity", for coverage purposes, means the individual is at least 100 pounds overweight or, if greater, 100% over his normal weight, and has continued to be so for at least 3 years despite documented unsuccessful attempts to reduce weight under a Physician monitored diet and exercise program;

(18) Charges for Prescription Drugs and medicines, unless specifically covered in connection with a Participant's admission to a Hospital or outpatient surgical facility;

(19) Charges by an Out-of-Network Provider; and

(20) Medical care and services for or related to the pregnancy of a Dependent child, including childbirth, miscarriage, abortion and any complications resulting from pregnancy.

ARTICLE II
PRESCRIPTION DRUG BENEFIT

Section 2.1 – Scope Of Prescription Drug Benefit

Participants who are enrolled in the POS Medical Benefit are also covered for the Prescription Drug Benefit as described in this Article. The Trustees may designate, from time to time, a third party administrator, pharmacy benefits manager, Network, Network Administrator and/or Claim Administrator in connection with delivery of the Prescription Drug Benefit. Any of the foregoing, to the extent designated, will be described in the Schedule of Benefits, and Participants will be notified of any changes thereto.

Section 2.2 – Network/Out-of-Network Pharmacies And Co-Payments

The terms, Network Pharmacy and Out-of-Network Pharmacy, as used in connection with the Prescription Drug Benefit, have the following meaning:

(a) **Network Pharmacy**: A Network Pharmacy means a retail or mail order pharmacy that participates in the Network offered to Participants under the Prescription Drug Benefit; and

(b) **Out-of-Network Pharmacy**: An Out-of-Network Pharmacy means a retail or mail order pharmacy that does not participate in the Network offered to Participants under the Prescription Drug Benefit.

When looking for a Network Pharmacy, if the logo for the designated pharmacy network is displayed at a retail pharmacy, it is a Network Pharmacy (or Network Provider). The Network for the Prescription Drug Benefit will designate at least one mail service pharmacy as a Network Pharmacy for Prescription Drugs obtained by mail order.

The level of benefits may differ depending upon whether a Prescription Drug is purchased from a Network Pharmacy or Out-of-Network Pharmacy and is often higher when a Network Pharmacy is used. The Schedule of Benefits describes the levels of coverage and limitations under the Prescription Drug Benefit for Network Pharmacies and Out-of-Network Pharmacies.

The term "Co-Payment", as used in connection with the Prescription Drug Benefit, means the amount payable by a Participant to the pharmacy for a Prescription Drug, depending upon the category of drug and whether it is a retail or mail order purchase from a Network Pharmacy or Out-of-Network Pharmacy.

Section 2.3 – Categories Of Prescription Drugs

The level of benefits depends in part upon the category of the covered Prescription Drug. Covered Prescription Drugs are divided into the following three categories:

(a) **Generic Drugs**: "Generic Drugs" are Prescription Drugs that are labeled with the medication's basic chemical name and that usually have a brand name equivalent. For example, Tagamet is the brand name for the Generic Drug Cimetidine. A Generic Drug must, by law, contain the same active ingredients and be available in the same strength and dosage as its brand name equivalent or counterpart. Generic Drugs are the most affordable way for a Participant to obtain quality medications at the lowest Co-Payment level, as indicated in the Schedule of Benefits;

(b) **Preferred Brand Name Drugs**: "Preferred Brand Name Drugs" are Prescription Drugs that either do not have a generic equivalent or are considered to be an effective alternative under the drug formulary for the Prescription Drug Benefit. Participants are covered for Preferred Brand Name Drugs at a slightly higher Co-Payment level, as indicated in the Schedule of Benefits; and

(c) **Non-Preferred Brand Name Drugs**: "Non-Preferred Brand Name Drugs" are brand name Prescription Drugs that can generally be effectively substituted with a Preferred Brand Name Drug or Generic Drug under the drug formulary for the Prescription Drug Benefit. This category has the highest Co-Payment level, as indicated in the Schedule of Benefits.

Section 2.4 – Brand Name Prescription Drug Deductible And Generic Drug Substitution

If a Participant has a prescription for a brand name drug for which there is a generic equivalent prescription drug (a "multi-source brand drug"), and the prescribing Physician directs that only the brand name medication may be issued (either by indicating "Dispense As Written" (DAW) or otherwise), the cost of the brand name medication is subject to a Brand Name Prescription Drug Deductible per family per calendar year as indicated in the Schedule of Benefits. This means the Participant and covered family members must pay out-of-pocket for multi-source brand drugs that are filled during the calendar year until they jointly satisfy the Brand Name Prescription Drug Deductible for the calendar year. Once that deductible is satisfied, any multi-source brand drug filled for any covered family member during the remainder of the calendar year will be covered subject only to payment of the applicable Co-Payment amount to the pharmacy.

If the Physician prescribes a multi-source brand drug and also provides a written statement, to the satisfaction of the Network Administrator for the Prescription Drug Benefit, that the Participant cannot take the Generic Drug for medical reasons unique to the Participant's situation, the multi-source brand name drug may be issued with a waiver of the family's Brand Name Prescription Drug Deductible for the calendar year.

If the Physician does not mark the multi-source brand drug as DAW, the Prescription Drug Benefit requires the pharmacist to substitute the Generic Drug for the brand name equivalent when the prescription is filled. The Participant will save money because he or she will be charged the Co-Payment for the Generic Drug rather than for the brand name drug. However, if the Participant insists on receiving the multi-source brand drug, he or she will be charged an

amount equal to the Co-Payment for a Generic Drug plus the excess cost of the multi-source brand drug, since the Prescription Drug Benefit covers only the amount that would have been paid if the Generic Drug had been substituted.

The family Brand Name Prescription Drug Deductible per calendar year applies to all multi-source brand drugs, whether filled at a retail or mail service Network Pharmacy or Out-of-Network Pharmacy. This deductible does not apply to prescriptions filled for Generic Drugs or for brand name drugs for which there is no equivalent Generic Drug.

Section 2.5 – Prescription Drug ID Card And Contact Information For Network Administrator

Each Participant will receive a Prescription Drug Benefit ID Card, which must be presented to the pharmacy each time a prescription is filled or refilled to ensure proper receipt of the Prescription Drug Benefit. If a Participant does not show the pharmacy his or her Prescription Drug Benefit ID Card, the prescription cannot be processed properly as a Network Pharmacy expense and may be processed as an Out-of-Network Pharmacy expense.

Any Participant who loses or damages his or her Prescription Drug Benefit ID Card must call the Network Administrator for the Prescription Drug Benefit immediately to request a replacement. The name of the Network Administrator and its contact information are listed in the Schedule of Benefits. A Participant who has a medical emergency and does not have the Prescription Drug Benefit ID Card with him or her should have a family member or friend bring it to the emergency room as soon as possible or call the Network Administrator on the Participant's behalf.

Section 2.6 – How To Purchase Prescription Drugs Under Prescription Drug Benefit Program

In order to receive the Prescription Drug Benefit, Participants should fill their prescriptions using one of the following methods:

(a) Any retail Network Pharmacy for up to a 30-day supply;

(b) Any retail Out-of-Network Pharmacy for up to a 30-day supply; or

(c) The designated Mail Service Network Pharmacy for up to a 90-day supply.

Except as otherwise specifically provided, Participants may refill a Prescription Drug through a retail pharmacy for up to a 30-day supply only once, and then must use the Mail Service Network Pharmacy in order for it to be covered. The Mail Service Network Pharmacy generally provides Participants with the lowest cost and most convenient Prescription Drug delivery method for up to a 90-day supply. Participants may also obtain Prescription Drugs for up to a 90-day supply at CVS retail pharmacies instead of using the Mail Service Network Pharmacy.

Using a Retail Network Pharmacy:

In order to have a prescription filled (or refilled) at a Retail Network Pharmacy, a Participant must show his or her Prescription Drug Benefit ID Card to the pharmacist and pay the Co-Payment amount that is due and, if applicable, any unsatisfied portion of the family Brand Name Prescription Drug Deductible. Any remaining amount that is owed will be covered by the Prescription Drug Benefit.

Using a Retail Out-of-Network Pharmacy:

In order to have a prescription filled (or refilled) at a Retail Out-of-Network Pharmacy, the Participant must pay the full cost of the Prescription Drug to the pharmacy when it is filled and request a receipt which includes the following information:

(a) The name and address of the dispensing pharmacy;

(b) The prescription number;

(c) The name of the Prescription Drug;

(d) The quantity dispensed;

(e) The date it is filled; and

(f) The cost of the Prescription Drug.

The Participant must then complete a claim form, and send it, with the pharmacy receipt attached, to the address shown on the claim form for processing. Claim forms may be obtained, free of charge, by calling the telephone number on the Prescription Drug Benefit ID card, through the Network's website, or from the Network Administrator.

The Network Administrator will process the claim and determine the amount of reimbursement payable to the Participant in the following manner:

(a) First, it will determine what the Prescription Drug would have cost had it been filled by a Network Pharmacy; and

(b) Then, it will deduct from the Network Pharmacy cost, the Co-Payment amount payable in accordance with the Schedule of Benefits.

Any additional cost is not reimbursable or covered under the Prescription Drug Benefit.

Example of Determination of Reimbursable Amount: Assume you have a Generic Drug filled at an Out-of-Network Pharmacy, and it costs $38. Also assume that the same Generic Drug, if filled at a Network Pharmacy, would have cost you $20. In order to receive benefits, you must pay the Out-of-Network Pharmacy $38 upfront; obtain and complete a claim form;

and send it, with a pharmacy receipt attached, to the Network Administrator. After the claim is processed, the reimbursable amount will be mailed to you.

In this example, you will be reimbursed $15 ($20 cost of Generic Drug from Network Pharmacy - $5 Generic Drug Co-Payment = $15 reimbursement). You are responsible for $23 ($38 - $20 = $18; $18 + $5 Co-Payment = $23).

Using the Mail Service Network Pharmacy:

Filling prescriptions through the Mail Service Network Pharmacy is easy and convenient. As discussed previously, the Mail Service Network Pharmacy must be used to fill most prescriptions after they have been filled and refilled once at a retail pharmacy in order for the prescription to be covered. If a Prescription Drug is refilled at a retail pharmacy after the first refill, it will not be covered under the Prescription Drug Benefit. The easiest way to begin using the Mail Service Network Pharmacy when your Physician prescribes a Prescription Drug which requires more than one refill, is to request a second prescription when your Physician writes the first prescription. This is how it works:

(a) The first prescription should be for a 30-day supply of the Prescription Drug, and it will allow for one refill. If your Physician is certain that the prescribed drug will not have to be adjusted or changed, he or she should give you the second prescription immediately. Otherwise, your Physician will provide the second prescription to you after it is certain that the prescribed drug is performing as expected; and

(b) The second prescription should be for a 90-day supply and allow for refills. This second prescription should be sent to the Mail Service Network Pharmacy together with a Prescription Drug form and the Co-Payment amount that is due (as well as any applicable deductible).

Payment may also be made with a credit or debit card. If you choose to use this method of payment and supply the Mail Service Network Pharmacy with your credit or debit card information, you may refill and pay for your prescription by telephone or online at the telephone number and website listed on the Schedule of Benefits and your ID card.

Mail Service Network Pharmacy Prescription Drug forms are available as follows:

(a) By calling the Network Administrator at the telephone number listed on your Prescription Drug Benefit ID Card and requesting a copy; or

(b) By visiting the Network Administrator's website, clicking on "Forms" and then "Prescription Form", and printing a copy.

The completed Mail Service Network Pharmacy Prescription Drug form, Physician's prescription, and payment for the Co-Payment and any applicable deductible, should all be sent to the Mail Service Network Pharmacy and address listed in the Schedule of Benefits. When you

order a Prescription Drug from the Mail Service Network Pharmacy, you should allow at least five to seven days for your prescription to arrive. Many people request a refill when they have a two week supply remaining to ensure that their medication supply does not run out. Your order will be delivered to your mailing address with postage paid in full. It is up to you to request a refill before your current prescription supply runs low to ensure that you can continue to take your medications without interruption.

When You Must Use the Mail Service Network Pharmacy

Except as otherwise provided below, all maintenance medications must be ordered through the Mail Service Network Pharmacy after they have been filled and refilled once, in order to be covered under the Prescription Drug Benefit. Examples of maintenance medications that must be filled through the Mail Service Network Pharmacy include, without limitation, medications taken on a regular basis for chronic conditions such as high blood pressure, arthritis, diabetes and asthma, as well as diabetic blood sugar level test strips. Except for prescription medications required for chemotherapy, Mail Service Network Pharmacy refills are limited to a 90-day supply.

Exceptions to Mandatory Use of Mail Service Network Pharmacy

The following prescription medications may be obtained at either a retail pharmacy or through the Mail Service Network Pharmacy program. In other words, they are specifically excepted from required use of the Mail Service Network Pharmacy program even though they may be maintenance medications:

(a) Insulin and syringes (but not blood sugar level test strips which must be purchased from a Mail Service Network Pharmacy);

(b) Miacalcin;

(c) Xalatan;

(d) Anti-infectives (antibiotics, anti-fungals and anti-virals);

(e) Topical medications (creams, gels and ointments);

(f) Vaginal medications (creams, gels and ointments);

(g) Controlled substances (may NOT be ordered from a Mail Service Network Pharmacy);

(h) Cough and cold medications; and

(i) Covered Prescription Drugs purchased from a CVS retail pharmacy.

You will be notified of any changes in the above list.

Paying for Prescription Drugs Obtained through the Mail Service Network Pharmacy

To receive an estimate of the total cost of your Prescription Drug order, you may call the Mail Service Network Pharmacy or Network Administrator. If your order includes Prescription Drugs that are subject to the family Brand Name Prescription Drug Deductible, the quotation should be regarded as an estimate. Keep in mind that the cost of Prescription Drugs changes frequently, and the price you owe will be the price on the day the Prescription Drug is shipped to you.

The fastest and easiest way to fill your prescription is to supply your credit or debit card number to the Mail Service Network Pharmacy or Network Administrator so your prescription will be filled immediately. You will receive a receipt with your prescription showing the actual amount charged to your credit or debit card. You may place your credit or debit card number on file with the Mail Service Network Pharmacy or Network Administrator so that future purchases will be expedited.

You may also opt to pay for your prescriptions by check or money order. However, due to the variation in drug costs from day to day, you may want to establish a small account with the Mail Service Network Pharmacy or Network Administrator so that funds are available as needed. Prescriptions will not be released unless there are sufficient funds in your account to cover your total cost for the prescription order. If your payment is insufficient to cover the cost of your prescription(s), a Member Accounts Receivable (AR) Representative may contact you to explain additional payment options that will expedite the shipment of your order.

Examples of Process When Paying for Prescriptions by Check or Money Order

Estimated Quote by Network Pharmacy	Actual Cost of Rx Order	Difference	End Result
$125.00	$118.00	$7.00 credit	$7.00 credit will be placed into an account with the Network Pharmacy to be applied to future purchases. Prescription shipped immediately.
$125.00	$125.00	$0	Paid in full. Prescription shipped immediately.
$125.00	$128.50	$3.50 due to Network Pharmacy	Balance of $3.50 due must be paid before prescription will be shipped.

Section 2.7 – Covered Prescription Drugs

The Prescription Drug Benefit covers Prescription Drugs that require a written prescription from a licensed Physician or other licensed medical provider authorized by law to write prescriptions. Your Physician may call in a prescription on your behalf directly to your local retail pharmacy or to the Mail Service Network Pharmacy. Insulin and other supplies for diabetes, such as syringes, needles and blood sugar level testing materials, are also covered under the Prescription Drug Benefit.

When you give a prescription to a pharmacy to be filled, the pharmacist will fill it with a Generic Drug unless no Generic Drug exists for that brand, or the prescribing Physician has specified "Dispense As Written" (DAW). If there is no Generic Drug equivalent for a brand name drug or medication, the brand name will be provided as ordered and covered under the Prescription Drug Benefit. If there is a Generic Drug equivalent, the cost of the Prescription Drug will be subject to the family's Brand Name Prescription Drug Deductible.

When Prior Approval for a Prescription is Required for Coverage

The following Prescriptions Drugs must be approved for coverage before you have the prescription filled in order to receive benefits:

(a) Alglucerase (treatment for liver, spleen and bone marrow conditions);

(b) Erythropoetin (used to treat anemia associated with HIV or its treatments);

(c) Filgrastim (helps the body make white blood cells to prevent infections);

(d) GM-CSF (used to treat non-Hodgkin's lymphomas and leukemia);

(e) Growth hormones; and

(f) Octreotide (used on growth hormones, certain tumors and gastrointestinal problems).

To get approval for any of the above medications, your Physician or licensed medical provider should call the Network Administrator at the toll-free number shown on the Prescription Drug Benefit ID Card.

Section 2.8 – Excluded Drugs or Medications

The following drugs or medications are excluded from coverage under the Prescription Drug Benefit:

(a) Drugs or medications that do not require a written prescription from a licensed Physician or other medical provider (including but not limited to over-the-counter remedies) unless specifically listed as covered, or for which there is a generic equivalent drug or medication that is available in non-prescription form;

(b) Compound prescription drugs or medications that do not have at least one ingredient that is a legend drug or medication requiring a prescription under federal or state law;

(c) Drugs or medications that are covered under another part of the POS Medical Benefit, or that are limited or excluded because they are experimental, investigational or not medically necessary;

(d) Drugs or medications that are covered under Workers' Compensation or any other government program (state, federal or municipal) that does not claim secondary payer status;

(e) Drugs, medications or devices for cosmetic purposes, hair growth, smoking cessation, anti-obesity, weight control, and contraception, except for oral contraceptives and the specific products Nuva-Ring and Ortho-Evra;

(f) Drugs or medications not approved by the U.S. Food and Drug Administration (FDA) or not approved by the FDA for the condition, dose, routine and frequency for which they are being prescribed;

(g) Drugs or medications provided at no charge to you or for which you would not have to pay in the absence of this or similar coverage;

(h) Drugs or medications required as a result of an act of war, declared or undeclared;

(i) Food, diet and nutritional supplements, except prescription vitamins and minerals; and

(j) Natural remedies (naturopathic) and homeopathic services, substances and supplies.

If you have questions about the Prescription Drug Benefit or want to determine if a particular drug or medication is covered, you can call the Network Administrator directly.

ARTICLE III
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT

Section 3.1 – Definitions

Whenever the following terms are used in this Article III as capitalized terms, they will have the meaning set forth below (notwithstanding the "Definitions" Section of the Welfare Plan), unless otherwise plainly indicated by the context.

(a) **"Chronic Mental Condition"** means a Mental Health/Substance Abuse Condition for which a Participant has been hospitalized at least four times in his or her lifetime, with at least two occurring within the three year period immediately before the date on which the Participant obtains or seeks to obtain Mental Health/Substance Abuse Treatment services.

(b) **"Covered Services"** means Mental Health/Substance Abuse Treatment Services that are Medically Necessary and covered under the Mental Health and Substance Abuse Benefit as described in this Article III.

(c) **"Emergency Treatment"** means Medically Necessary services to treat a Participant's sudden, unexpected acute symptoms of mental illness or substance abuse which are so severe that, without immediate treatment, could reasonably cause serious injury to life or limb and/or immediate jeopardy to the Participant's health.

(d) **"Family Unit"** means a Retired Employee and his or her Dependents who are covered by the Welfare Plan.

(e) **"Medically Necessary"** means, for purposes of the Mental Health and Substance Abuse Benefit, a determination by the Network Manager that a particular Mental Health/Substance Abuse Treatment Service meets all of the following criteria:

(1) It is appropriate for the symptoms, diagnosis and treatment of a particular disease or condition that is defined under the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) of the American Psychiatric Association, (DSM-IV) or its replacement;

(2) It is provided in accordance with generally accepted standards of Mental Health and Substance Abuse professional practice;

(3) It is provided for the diagnosis or direct care and treatment of a disease or condition that is defined under DSM-IV or its replacement;

(4) It is not rendered mainly for the convenience of the Participant, the Participant's family or the provider; and

(5) The type, level and length of treatment services are needed to provide safe and adequate care and are reasonably likely to improve a Participant's condition and not merely to maintain the current level of functioning. For inpatient stays, this means that because of the symptoms or condition, the Participant cannot receive safe and adequate care as an outpatient or in another less intensive setting.

(f) **"Mental Health/Substance Abuse Condition"** means a nervous, mental, or substance abuse condition that satisfies all of the following requirements:

(1) It is a clinically significant behavioral or psychological syndrome or pattern;

(2) It is associated with present distress or substantial or material impairment of the patient's ability to function in one or more major life activities (e.g., employment);

(3) It is not merely an expectable response to a particular event (e.g., the death of a loved one); and

(4) It is listed as an Axis I disorder (other than a V Code of the DSM-IV or its replacement).

(g) **"Mental Health/Substance Abuse Treatment Services"** means psychiatric and/or other mental health services for a Mental Health/Substance Abuse Condition.

(h) **"Network Provider"** means, for purposes of the Mental Health and Substance Abuse Benefit under this Article III, a Provider or facility that is licensed under applicable state law and contracts with or is employed by the Network Manager to deliver Mental Health/Substance Abuse Treatment Services to Participants.

(i) **"Provider"** means a licensed psychiatrist, licensed psychologist, licensed chemical dependency therapist, licensed psychiatric nurse, social worker (licensed or accredited by the Academy of Clinical Social Workers), or other health care provider or facility as described in this Article III, that is licensed or certified under the laws of the State in which the services are delivered.

(j) **"Structured Outpatient Services"** means a structured treatment program consisting of multiple sessions of Mental Health/Substance Abuse Treatment Services in each 7 day period, with each session no shorter than 2 hours and no longer than 12 hours in any 24-hour consecutive period. It may also be referred to as intensive outpatient treatment, partial hospitalization, or day hospitalization, and for coverage purposes includes Residential Treatment Programs.

Section 3.2 – Scope Of Coverage And Required Use Of Network Providers

The Mental Health and Substance Abuse Benefit covers only the services as described in this Article III, when coordinated through the Network Manager and received from Network Providers, and subject to the limits described in the Schedule of Benefits.

Section 3.3 – Limitations And Exclusions

Notwithstanding any provision to the contrary, the following services, treatments and supplies are **not** Covered Services and are **not** covered under the Mental Health and Substance Abuse Benefit, so any related expenses incurred will **not** be covered:

(a) Services, treatment and supplies provided by an Out-of-Network Provider, except for Emergency Treatment;

(b) Services, treatment and supplies provided without the required Pre-Certification, except for Emergency Treatment; effective January 1, 2013, Pre-Certification is not required for outpatient procedures as a condition of coverage but continues to be required for inpatient procedures as a condition of coverage;

(c) Services, treatment and supplies which are not Medically Necessary;

(d) Services, treatment and supplies which are primarily for rest, custodial, domiciliary or convalescent care;

(e) Diagnosis and treatment for personal growth and/or development, personality reorganization or in conjunction with professional certification;

(f) Services, treatment and supplies which are determined to be experimental;

(g) Private hospital rooms and private duty nursing, unless determined to be Medically Necessary and authorized by the Network Provider;

(h) Expenses incurred for broken appointments except in cases where the Network Provider is notified at least 24 hours before the appointment time, otherwise a charge of no more than $25.00 will be billed directly to the Participant as a broken appointment charge;

(i) All Prescription Drugs and non-Prescription Drugs, unless prescribed by a Network Provider in the course of inpatient treatment;

(j) Marriage counseling except for treatment of a Mental Health/Substance Abuse Condition;

(k) Treatment of congenital and/or organic disorders, including but not limited to organic brain disorder and Alzheimer's disorder;

(l) Treatment of mental retardation other than the initial diagnosis;

(m) Diagnosis and treatment of developmental disorders, including but not limited to developmental reading disorders, developmental arithmetic disorders and developmental articulation disorders;

(n) Ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training and education therapy for learning disabilities and other education services;

(o) Services, treatment and supplies provided as a result of any Worker's Compensation or similar law, or obtained through or required by any governmental agency or program, whether federal, state or any subdivision thereof, or caused by the conduct or omission of a third-party for which you have a claim for damages or relief, unless you provide the Network with a lien against such claim for damages or relief in a form and manner satisfactory to the Network Manager;

(p) Any court-ordered diagnosis or treatment, including any diagnosis or treatment ordered as a condition of parole, probation or custody or a visitation evaluation, unless and except to the extent it is Medically Necessary;

(q) Psychological examination, testing and treatment for purposes of satisfying a current or prospective employer, or any requirements for obtaining employment, licensing or insurance, or for the purpose of judicial or administrative proceedings (including but not limited to parole or probation proceedings);

(r) Other psychological testing except when conducted for the purpose of diagnosis of a Mental Health/Substance Abuse Condition;

(s) Services, treatment and supplies for military services and other disability;

(t) Treatment of detoxification in newborns;

(u) Treatment of obesity, weight reduction, and smoking cessation (including supplies);

(v) Stress management therapy and aversion therapy;

(w) Treatment of pain, except for Medically Necessary treatment of pain with psychological or psychosomatic origins but not including tension headaches;

(x) Sex therapy, treatment for sexual deviance, and diagnosis and treatment in conjunction with sexual reassignment procedures;

(y) Damage or other harm to a Network Provider caused by you (Participants will be solely responsible for all such damage or harm);

(z) Treatment for a Chronic Mental Condition, except for (i) stabilization of an acute episode of such disorder, or (ii) management of medication;

(aa) Any mental illness or substance abuse illness for which the individual has received treatment in the first six months immediately prior to commencement of coverage under the Plan;

(bb) Frontal Lobe Syndrome;

(cc) Post Concussion Syndrome; and

(dd) Gilles de Touret's Syndrome.

Section 3.4 – Grievance Procedure For Disputes And Complaints

The Network Manager maintains a voluntary internal grievance procedure for resolving Participants' disputes or complaints with the Network Manager or with any Network Provider. You may call the Network Manager at the telephone number listed in the Schedule of Benefits, to discuss any inquiries or complaints about the Network Manager, any Network Provider or any other related matter. If the Network Manager does not satisfy your concern by telephone, you may file a complaint by completing a complaint form and sending it to the Network Manager at the address listed in the Schedule of Benefits.

Copies of complaint forms and grievance procedure for Network matters are available at Network Provider offices and upon request to the Network Manager. Assistance will be provided by a Network representative to any Participant who files a grievance. Neither the Network Manager nor any Network Provider will discriminate against a Participant for filing a complaint.

Within twenty (20) days of receiving a Participant's complaint, the Network Manager will contact the Participant to acknowledge receipt, solicit details as needed and conduct an investigation. The Participant will then be notified of the disposition of the complaint. If it is not resolved to the Participant's satisfaction, the Participant will have 30 days to request that his or her complaint be reviewed by the Network's Grievance Committee. The Grievance Committee will review the complaint further and notify the Participant of its decision within thirty (30) days of receiving a request for review. The Grievance Committee will also investigate any alleged retaliation and take appropriate action.

In addition to this Grievance Procedure, there is also a Claims Procedure and Claims Review Procedure maintained in accordance with the requirements under the federal law known as ERISA. Those procedures are described in greater detail in the general provisions for the Welfare Plan. Participants should review those procedures to learn more about their rights and obligations with regard to filing claims for benefits and requesting a review when a claim is denied in whole or part.