

PLUMBERS AND PIPEFITTERS LOCAL UNION 344 HEALTH  
AND WELFARE PLAN

Plan Document  
and  
Summary Plan Description

Restatement Effective January 1, 2024  
(unless stated otherwise)

**PLUMBERS AND PIPEFITTERS LOCAL UNION 344**

**HEALTH AND WELFARE PLAN**

**WITNESSETH:**

WHEREAS, the Plumbers and Pipefitters Local Union 344 Joint Board of Trustees desires to recognize the contribution made to the successful operation of the Union by its members and to reward such contribution by means of a health and welfare plan for those members who shall qualify as Participants hereunder;

WHEREAS, the Joint Board of Trustees adopted this Plumbers and Pipefitters Local Union 344 Health and Welfare Plan (the "Plan") originally effective as of January 1, 2011.

NOW, THEREFORE, effective January 1, 2024, the Joint Board of Trustees hereby amends and restates the Plan for the exclusive benefit of the Participants and their covered Dependents, on the following terms.

This Plan has been executed the \_\_\_\_ day of \_\_\_\_\_, 2023.

**PLUMBERS AND PIPEFITTERS LOCAL 344**

**CONTRACTOR TRUSTEES**

By: \_\_\_\_\_

Name: \_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_

**PLUMBERS AND PIPEFITTERS LOCAL 344**

**UNION TRUSTEES**

By: \_\_\_\_\_

Name: \_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_

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## ARTICLE 1 INTRODUCTION

This restated Plumbers and Pipefitters Local Union 344 Health and Welfare Plan (the “Plan”) shall be effective January 1, 2024. The Plan may be amended at any time, in whole or in part, by the Joint Board of Trustees.

The Plan has been approved by the Joint Board of Trustees of the Plan which is the named Plan Administrator. The Plan intends to meet the requirements of:

- The Employee Retirement Income Security Act of 1974 (“ERISA”); and
- The Regulations promulgated thereunder, as amended from time to time.

This document and any amendments constitute the governing document of the Plan. This Plan is a multiemployer plan, designed and administered exclusively for the Participants of the Plan. You are entitled to this coverage if the provisions in the Plan have been satisfied. This Plan is void if you lose entitlement to coverage. No clerical error shall invalidate such coverage if otherwise validly in force.

The Joint Board of Trustees, as the Plan Sponsor, intends to maintain the Plan indefinitely. However, the Plan Sponsor has the right to modify or terminate the Plan at any time, and for any reason, as to any part or in its entirety, without advance notice. Article 15 describes what will happen to your benefits if the Plan is amended or terminated.

**Identification Card.** You will receive an identification card (“ID card”) to show to providers when you need to use your benefits. Carry your card with you at all times. Your personal identification number is also on your card. All of your eligible Dependents share your identification number. Legal requirements govern the use of your card. It is illegal to allow anyone who is not an enrolled Participant or Dependent to use your card or your benefits.

### Capitalized Terms

Some of the terms used in this document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary at the end of this Plan Document or in other relevant Articles. When reading the provisions of the Plan, you can refer to the Glossary at the end of this document. Becoming familiar with the terms defined there will give you a better understanding of the procedures and benefits described herein.

**ARTICLE 2 PLAN IDENTIFYING INFORMATION**

<b>Name of the Plan</b>	Plumbers and Pipefitters Local Union 344 Health and Welfare Plan
<b>Type of Plan</b>	Health and Welfare Plan
<b>Funding Medium and Type of Plan Administration</b>	The Plan receives Contributions from Employers subject to a collective bargaining agreement and holds those assets in trust for the exclusive benefit of Participants.
<b>Address of Plan</b>	4337 S. W. 44 <sup>th</sup> Oklahoma City, OK 73119
<b>Agent for Service of Legal Process</b>	Business Manager Local 344 4337 S. W. 44 <sup>th</sup> Oklahoma City, OK 73119
<b>Plan Number/Tax Identification</b>	501/73-0950060
<b>Restatement Effective Date</b>	January 1, 2024 unless stated otherwise.
<b>Plan Year End</b>	December 31
<b>Plan Administrator</b>	Joint Board of Trustees of the Plumbers and Pipefitters Local Union 344
<b>Claims Administrator</b>	Benefit Resources, Inc. 8441 Gulf Freeway, Suite 304 Houston, TX 77017
<b>Board of Trustees</b>	Larry Brouk, Local Union 344 4337 SW 44th St., Oklahoma City, OK 73119
	James Clouse, Local Union 344 4337 SW 44th St., Oklahoma City, OK 73119
	Gary Cartwright, Local Union 344 4337 SW 44th St., Oklahoma City, OK 73119
	Chas Gilmore, United Mechanical 117 NE 38th Ter., Oklahoma City, OK 73105
	Kevin Cockerham, Streets, Inc. 100 SE 25th St., Oklahoma City, OK 73129
	David Hames, Quality Plumbing 431 Highland Parkway, Norman, OK 73070

**Preauthorization Providers**

Medical Claims:  
Medical Management  
1-800-433-3232

Prescription Claims:  
CVS/Caremark  
[www.Caremark.com](http://www.Caremark.com)  
Member Services: 1-800-334-8134  
Pharmacy Help Desk: 1-800-364-6331

**ARTICLE 3 SCHEDULE OF BENEFITS**

All benefits are subject to the Plan’s terms and conditions, including Deductibles, Coinsurance, In-Network discounts and the Applicable Plan Limit.

Dental benefits are administered by Delta Dental and funded through a self-insured trust.

Benefit percentages payable by the Plan may change depending upon whether you obtain covered services from an In-Network Provider. The list of In-Network Providers may change from time to time. A current list of In-Network Providers is available, without charge, through the website located at [www.uhc.com](http://www.uhc.com). Covered Persons may also contact the PPO network at the phone number on the Plan ID card. It is important to verify that the Provider who is treating you is currently an In-Network Provider.

**General Provisions**

Deductibles	In-Network	Out-of-Network
<b>Calendar Year Deductible for Major Medical Benefits</b>		
Individual	\$300	\$300
Family	\$900	\$900
Hospital Inpatient	None	\$250 (per confinement in addition to Deductible)
Prescription Drugs: \$100 per each Covered Person per Calendar Year; in addition to Calendar Year Deductible.		
<b>Calendar Year Out-of-Pocket Maximum for Major Medical Benefits</b>		
The following charges do not apply toward the Out-of-Pocket Maximum and are never paid at 100%: cost-containment penalties, amounts over reasonable and customary charges, Prescription Drug Copayment/Coinsurance or Deductible (see Prescription Drug Out-of-Pocket Maximum) and Hearing Aids.		
Individual	\$3,300	Unlimited
Family	\$6,600	Unlimited
<b>Calendar Year Out-of-Pocket Maximum for Prescription Drug Benefits</b>		
The following charges do not apply toward the Out-of-Pocket Maximum and are never paid at 100%: cost-containment penalties, amounts over reasonable and customary charges, Major Medical Copayment/Coinsurance or Deductible (see Major Medical Out-of-Pocket).		
Individual	\$3,300	Unlimited
Family	\$6,600	Unlimited
<b>Coinsurance:</b> After the Deductible, benefits will generally be paid at 80% for In-Network charges and 50% Out-of-Network charges up to the Out-of-Pocket Maximum limits listed above unless stated otherwise. The Plan will pay 100% of covered In-Network PPO charges after the In-Network Out-of-Pocket Maximum is met for an applicable year. Out-of-Network, non-PPO charges are not limited to any out-of-pocket limit and are never allowed at 100%. If you are 50 miles away from a PPO facility, the Out-of-Network Coinsurance rate of 50% is increased to 80%.		

Preventive Medical Benefits	In-Network	Out-of-Network
<p><b>Physical Examinations</b></p> <p><i>St. Anthony SCORE Program – Participants and Retirees who are covered by the Plan are eligible to participate in the St. Anthony SCORE Program. Refer to Article 20 for more information.</i></p>	<p>Once every Calendar Year if over 40; once every two Calendar Years if under 40.</p>	
<p><b>Preventive Health Services</b></p> <p><i>As required by Section 2713 of the Public Health Service Act, including:</i></p> <ul style="list-style-type: none"> <li>• Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force</li> <li>• Immunizations for routine use recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</li> <li>• Evidence-informed preventive care and screenings provided in the comprehensive guidelines supported by the Health Resources and Services administration (“HRSA”) for infants, children, and adolescents</li> <li>• Evidence-informed preventive care and screenings provided in comprehensive guidelines supported by HRSA for women as described below</li> <li>• Screenings and services considered to be “Free Preventive Services” as listed on <a href="http://www.healthcare.gov">www.healthcare.gov</a>, including but not limited to: alcohol misuse screening and counseling, blood pressure screening, colorectal cancer screening for adults over age 50, diet counseling, HIV screening, immunization vaccines, obesity screening and counseling, and tobacco use screening</li> </ul>	<p>100%</p>	<p>50%</p>



<ul style="list-style-type: none"> <li>Effective May 12, 2023 (see the COVID-19 Addendum for coverage prior to May 12, 2023), qualifying coronavirus preventive services (as defined below)</li> </ul>		
<p><b>Women’s Preventive Services</b></p> <p><i>As required by the HRSA including but not limited to:</i></p> <ul style="list-style-type: none"> <li>Well-woman visits</li> <li>Screening for gestational diabetes</li> <li>Human papillomavirus testing</li> <li>Counseling for sexually transmitted infections</li> <li>Counseling and screening for human immune-deficiency virus</li> <li>Contraceptive methods and counseling</li> <li>Breastfeeding Support (as defined in Article 7)</li> <li>Screening and counseling for interpersonal and domestic violence</li> </ul>	<p>100% subject to time limits below</p> <p>Annually</p> <p>In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes</p> <p>No more than one time every three years beginning at age 30.</p> <p>Annually</p> <p>Annually</p> <p>As prescribed</p> <p>In conjunction with each birth</p>	<p>50%</p>

**Note:** The preventive medical benefits listed above are not subject to the Plan’s Deductibles.

<b>Covered Benefit</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Allergy Testing and Treatments</b>	80%	50%
<b>Ambulance Service</b>	80%	80%
<b>Ambulatory Surgical Facility Services</b>	80%	50%
<b>Diagnostic Charges and Pre-Admission Testing</b>	80%	50%
<b>Durable Medical Equipment</b>	80% over 12 months not to exceed purchase price. The Plan will pay 100% of replacement parts with a maximum allowance of one replacement part every five years.	50%
<b>Emergency Care Facility</b> (to include all related ancillary services performed in the Emergency Care Facility)	80%	80%
<b>Extended Care Facility and Rehabilitation</b> <i>10 Days Combined Calendar Year Maximum Benefit</i>	80%	50%
<b>Habilitation Services</b> <i>Limited to 25 visits per Calendar Year</i>	80%	50%
<b>Skilled Nursing Facility</b> <i>30 days Calendar Year Maximum Benefit</i>	80%	50%
<b>External Prosthetic Appliances</b> <i>Limited to one appliance every 36 months</i>	80%	50%
<b>Hearing Aids</b> <i>Limited to \$1,500 per ear every five years</i> <i>No coverage for Retirees</i>	100%	100%
<b>Home Health Care</b> <i>Limited to 30 visits every Calendar Year</i>	80%	50%
<b>Hospice Care</b> Inpatient/Outpatient Services <i>Limited to six months every three years</i>	80%	50%

<b>Hospital Expenses</b> <i>Covered room &amp; board charge daily rate</i>	80% Failure to obtain Preauthorization results in \$250 fee	50% Failure to obtain Preauthorization results in \$250 fee
<b>Injury</b>	80%	50%
<b>Intensive Care Unit</b>	80%	50%
<b>Laboratory and Radiology Services</b> <i>(in or out of Physician's office)</i>	80%	50%
<b>Maternity Care, Including Delivery</b>	80%	50%
<b>Mental Health Conditions</b>	80%	50%
<b>Inpatient Care Drug or Alcohol - Excluded</b>	0%	0%
<b>Outpatient Care Drug or Alcohol - Excluded</b>	0%	0%
<b>Outpatient Hospital Expenses</b> <i>(Facility Charges)</i>	80%	50%
<b>Outpatient Occupational and Physical Therapy</b> <b>Effective August 1, 2022, Speech Therapy</b> <b>ABA Therapy for Autism</b> <i>All limited to 26 visits per Calendar Year</i>	80%	50%
<b>Physician Office Visits</b> Effective December 1, 2020, certain services provided at certain Just Kids Pediatrics and Your Health and Wellness locations <i>See Section 7.02 for applicable clinic locations and covered services</i>	80% 100% No Copay, Deductible, or Coinsurance	50% N/A
<b>Private Duty Nursing Outpatient</b> <i>Limited to 30 days per Calendar Year</i>	80%	50%
<b>Professional Services</b> <i>Inpatient and Outpatient (other than office visits) surgeon, radiologist, pathologist, anesthesiologist</i>	80%	50%

<b>Second Surgical Opinion</b>	80%	50%
<b>Spinal Manipulation Treatment/ Chiropractic Care</b> <i>Limited to 26 visits per Calendar Year</i>	80%	50%

**Please Note:**  
Maximum benefit limits do not guarantee that all services will be approved to the maximum number allowed under this Plan. Payments that are on a percentage basis will be applied to the contracted allowed amount reimbursed to the Provider, if applicable.

**Prescription Drug Benefit**

Prescription Drug Benefits after \$100 Deductible

<b>TYPE</b>	<b>RETAIL</b>	<b>MAIL ORDER</b>
<b>Generic</b>	\$10 Copay	\$20 Copay
<b>Preferred Brand</b>	80% Coinsurance	80% Coinsurance
<b>Non-Preferred Brand</b>	75% Coinsurance	75% Coinsurance
<b>Specialty</b>	Same as Preferred or Non-Preferred Brand	Same as Preferred or Non- Preferred Brand

**Employee Assistance Program**

The Plan has contracted with Unity Health Services to provide confidential EAP crisis intervention, counseling, and referral services to Participants and Retirees and their eligible Dependents. The Plan provides for 8 visits per Calendar Year.

Should you or one of your Dependents be in a stressful situation and in need of these services, please call 1-800-413-8008 ext. 2, or 1-314-729-4650. Crisis intervention specialists are available on a 24-hour-a-day basis. If it is not an emergency situation, an appointment with a licensed counselor will be scheduled within 1 to 3 days.

You will be referred to the appropriate counselor based upon your situation. For example, counseling services are provided for job-related stress, marital stress, alcohol abuse and drug addiction, financial and legal problems, depression and anxiety, etc. Please see the separate EAP brochure for a complete description of services.

**Remember, Plan benefits are paid from the assets of the Fund. Be a wise consumer of services. Use your PPO, St. Anthony's SCORE Program, the EAP, and the Just Kids Pediatrics/Your Health and Wellness locations whenever possible. It is your Fund and your money.**

## ARTICLE 4 ENROLLMENT, ELIGIBILITY, AND CONTRIBUTIONS

### Section 4.01. Eligibility Rules for Active Employees.

#### A. Initial Eligibility.

1. Bargaining Employees: Active Employees of a Contributing Employer (as each are defined in the Glossary and with respect to whom Contributions are made or are required to be made to the Fund for the maintenance of a health and welfare plan) shall be eligible for Plan benefits as of the first day of the second calendar month following a period of not more than 12 consecutive calendar months during which he/she worked at least 600 hours for Contributing Employers.

If contributions are made to the Fund under the terms of a collective bargaining agreement negotiated by a participating local union which allows for a rate other than the rate agreed to by the Joint Board of Trustees, those hours shall be credited as a percentage of the credited hours of the agreed-to construction contribution rate.

2. Non-Bargaining Employees: A Non-Bargaining Employee is eligible to participate in the Plan who is:
  - a. a salaried employee;
  - b. a full-time employee regularly scheduled to work at least 40 hours per week; and
  - c. not the spouse of a Union Employee who is covered under the Plan (spouses of Union employees who are covered by the Plan must be enrolled as a dependent of the Union Employee).

Coverage for eligible Non-Bargaining Employees will be effective as of the first day of the month following the month in which the Non-Bargaining Employee is first hired or, if later, the first day of the month following the month in which the non-bargaining employer first executes a participation agreement.

Non-Bargaining Employees do not have an Hour Bank Account as outlined in the other sections of this Plan and will not accrue any hour bank hours.

Non-Bargaining Employees must enroll within 30 days of initial employment (or, if later, the employer's execution of the participation agreement). If a Non-Bargaining Employee does not enroll by that deadline, the Non-Bargaining Employee must wait until the next Open Enrollment Period or permissible mid-year enrollment event to enroll.

- B. **Special Eligibility Provisions for Employees of Newly Organized Employers.** If you are an Employee of an Employer who becomes a signatory to a collective bargaining agreement with the Plumbers and Pipefitters Local Union 344, you will become eligible the first day of the second calendar month following the effective date of the collective bargaining agreement as applied to the new signatory Employer.

**Example 1:** Your Employer executes a collective bargaining agreement with the Plumbers and Pipefitters Local Union 344 on January 1st. You will be eligible for Plan benefits on March 1st. Thereafter, 130 hours will be deducted from your Hour Bank Account for each month of coverage as explained in the Maintenance of Eligibility section.

**Example 2:** Your employer executes a collective bargaining agreement with the Plumbers and Pipefitters Local Union 344 on May 2nd. You will be eligible for Plan benefits on July 1st.

Thereafter, 130 hours will be deducted from your Hour Bank Account for each month of coverage as explained in the Maintenance of Eligibility section.

**Example 3:** On the other hand, if your Employer became signatory to a Collective Bargaining Agreement with the Plumbers and Pipefitters Local Union 344 on January 1st, but you were hired after that date, the Initial Eligibility rules will apply to you.

- C. **Maintenance of Eligibility.** An Hour Bank Account is established for each Employee other than Non-Bargaining Employees. For the initial month of coverage and each month of coverage thereafter, 130 hours shall be deducted from the Employee's Hour Bank Account. An Employee shall continue to remain covered as long as his/her Hour Bank Account contains at least 130 hours after deduction for the current month's coverage.

After deduction for the current month's coverage, the maximum number of hours in an Employee's Hour Bank Account may not exceed 780 hours for those Employees who become eligible under the terms and provisions of this Plan.

In the event an Employee accepts and/or continues Competitive Employment with a non-Contributing Employer, all hours accumulated in his/her Hour Bank Account shall be forfeited.

**Reciprocating Hours and Contributions.** Your credited hours also include hours worked in another geographic jurisdiction that are reciprocated by the other local. Hours worked at contribution rates other than the Union construction contribution rate will be credited by dividing the total contribution received from the other local by the Union construction contribution rate then in effect.

**Example:** Assume the Plumbers and Pipefitters Local Union No. 344 hourly contribution rate is \$7.38, and the contribution rate of the local union in the jurisdiction where you are working is \$5.00. In this case, if you work 100 hours during a month, you would be credited with 67.75 hours. The calculation is shown below:

$$100 \text{ hours} \times \$5.00 = \$500 \text{ contribution from other local}$$

$$\$500 \div 7.38 = 67.75 \text{ hour bank hours}$$

On the other hand, if the reciprocating local union's hourly contribution rate is \$6.50 you would be credited with 88.08 hours. The calculation is shown below:

$$100 \text{ hours} \times \$6.50 = \$650 \text{ contribution from other local}$$

$$\$650 \div 7.38 = 88.08 \text{ hour bank hours}$$

- D. **Termination of Eligibility for Participants.** Your eligibility shall terminate, generally, on the last day of the month in which one of the following occurs.
1. With respect to Employees who are not Non-Bargaining Employees, you have less than 130 hours in your Hour Bank Account after deduction for the current month's coverage or fail to meet any other eligibility requirements unless otherwise required by law, including FMLA.
  2. You enter full-time active duty in the Armed Forces of the United States unless otherwise required by law under the terms and provisions of USERRA.
  3. You fail to make any required self-payment (including during Disability).
  4. You engage in Competitive Employment.

5. The date on which the Trustees terminate the Plan, in which case eligibility will terminate on that date.
  6. The date on which there are insufficient assets left in the Fund to pay benefits, in which case eligibility will terminate on that date.
  7. While on an Approved Leave of Absence, you become employed full-time by another employer and are eligible for health benefits.
  8. Your coverage is terminated for cause (filing fraudulent claims or you misuse the ID card or benefits).
  9. With respect to Non-Bargaining Employees, termination of employment.
- E. **Eligibility During Periods of Disability.** If, after an Active Employee meets the eligibility requirements, he/she becomes unable to work because of a non-occupational Disability, he/she shall be credited, for eligibility purposes, with 35 hours for each week of such Disability, up to a maximum of 400 hours during any one Calendar Year. An Employee shall be considered Disabled if he/she is certified as such by his or her doctor. An Employee is considered Disabled if he/she is Partially Disabled or Totally Disabled as defined in Article 21, Short-Term Disability, of this SPD.

**Section 4.02. Reinstatement of Eligibility.**

- A. If your eligibility terminates because you do not have the required hours in your Hour Bank Account, your Hour Bank Account may only be reinstated if you make continuous, monthly self-payments during the period of your unemployment. If you do not maintain eligibility through self-pay, your Hour Bank Account will be forfeited after 12 months. Continuing coverage through self-pay will not result in hours being credited to your Hour Bank Account.
- B. If your Hour Bank Account returns to at least 130 hours within 12 months of your eligibility termination, you will be reinstated the first day of the second calendar month following the month you have enough hours unless you resign or are employed pursuant to workers' compensation. You are permitted to make partial or full self-payments during this 12-month period. If you do not work at least 130 hours within 12 months of your termination, you will not be reinstated until you have worked 400 hours plus one month for reporting. In either case, you must continue to be a member in good standing of the Union throughout your termination period, or you will be reinstated as a new Employee required to accrue 600 hours plus one month for reporting.

**Section 4.03. Becoming Covered – Example**

WORK MONTH	HOURS WORKED	HOUR BANK	WITHDRAWAL	HOUR BANK MAX 780 HOURS	BENEFIT MONTH
Jan.	75	75			
Feb.	90	165			
March	95	260			
April	75	335			
May	100	435			
June	100	535			

July	75	610	130	480	Sept. (first elig.)
Aug.	-0-	480	130	350	Oct.
Sept.	40	390	130	260	Nov.
Oct.	30	290	130	160	Dec.
Nov.	-0-	160	130	30	Jan.
Dec.	-0-	30	-0-	30	Feb. (self-pay)

Your Hour Bank Account is limited to a maximum of 780 hours after deduction for the current month's coverage. This Hour Bank Account of 780 hours provides you with up to 6 months of continuing coverage.

**Section 4.04. Self-Payment Provisions for Active Employees.**

- A. **Loss of Eligibility.** If an Active Employee loses eligibility for life insurance, accidental death and dismemberment, or comprehensive medical, dental, and vision benefits under this Plan because of insufficient hours in his/her Hour Bank Account (and loss of eligibility is not due to a termination of employment for gross misconduct), he/she and/or his/her eligible Dependents may continue such coverage by making self-payments directly to the Fund Office, provided the individual does not become covered as an employee or a dependent under any other group health plan, unless that other plan contains an exclusion or limitation for any pre-existing condition of such individual, in which case he/she may continue to make payments and be covered. For purposes of this Section, the term Active Employee includes an individual who was an Employee covered under the Plan, is not currently working for a Contributing Employer, but is still covered under the Plan, without any interruption in such coverage, due to sufficient hours in his/her Hour Bank Account or as a result of continued coverage in accordance with either FMLA or USERRA.

Additionally, an Employee's Dependents may continue comprehensive medical, dental, and vision benefits under this Plan by making self-payments directly to the Fund Office if eligibility for Fund benefits is lost because of one of the following reasons (provided that the Dependent does not become covered under another group health plan as an employee or a dependent unless such other plan contains an exclusion and/or limitation for any pre-existing condition of such Dependent):

1. the death, divorce, or legal separation of an Active Employee;
  2. eligibility for Medicare by an Employee who is continuing coverage in accordance with this Section;
  3. in the case of a dependent child, the failure of such Dependent to meet the definition of Dependent; or
  4. the Active Employee loses coverage due to insufficient hours in his/her Hour Bank Account (other than by reason of gross misconduct) and he/she does not elect Continuation Coverage for a dependent child.
- B. **Notice.** The Fund Office shall notify all Active Employees and spouses of their rights under this Section at the Employee's commencement of coverage under the Plan. The Fund Office shall also notify (at his/her last known address) an Active Employee who has lost coverage because of insufficient hours.



The Fund Office must be notified of the death of an Active Employee (if such death occurs prior to his/her termination of employment) or the Medicare entitlement of any Employee who is continuing coverage under this Section (if the Employee is still employed by a Contributing Employer) within 60 days of a loss of an Employee's Plan benefits due to such event. If a Dependent's coverage under the Plan is affected by (1) divorce or legal separation of an Active Employee, (2) the death of an Active Employee after his/her termination of employment, (3) an Employee's eligibility for Medicare who is continuing coverage in accordance with this Section (at a time when he/she is no longer employed by a Contributing Employer), or (4) the failure of a dependent child to meet the definition of Dependent, the Dependent is responsible for notifying the Fund Office of those facts within 60 days of the event.

1. Any Active Employee or Dependent who is disabled (within the meaning of Title II or XVIII of the Social Security Act, as amended) at the time of the loss of coverage due to insufficient hours must also notify the Fund Office within the earlier of:
  - a. 60 days of the date of such determination of disability;
  - b. the end of the 18-month normal coverage period under this Section; and
  - c. 30 days of the date the Employee or Dependent is determined to no longer be disabled.

2. The Fund Office shall then notify the Employee or Dependent of his/her rights under these provisions by the later of 30 days:
  - a. after its notice from the Contributing Employer, Employee, or Dependent, or its own determination of loss of hours; or
  - b. before coverage would actually end.

Any notification to an Employee's spouse shall be deemed notification to all other Dependents residing with such spouse at the time of the notice.

3. Each Employee or Dependent shall have 60 days after the later of:
  - a. the notice from the Fund Office; or
  - b. the date eligibility is lost

to notify the Fund Office of the election to continue eligibility by making self-payments.

Unless otherwise specified in an election, any election by an Employee or his/her spouse shall be deemed also to be an election on behalf of all other Dependents who would lose coverage due to the qualifying event.

- C. **Self-Payment Amounts and Benefits Available.** The amount of the monthly self-payment(s) shall be established by the Board of Trustees and is subject to change at its discretion. The self-payment(s) charged shall represent continuation of life insurance, accidental death and dismemberment, and comprehensive medical, dental, and vision benefits provided by the Plan for Active Employees and Dependents. During the first 18 months of Continuation Coverage, the monthly self-payment rate shall be established by the Board of Trustees. During this first 18-month period, in no event shall the monthly self-payment amount exceed 102% of the applicable premium, as determined under Section 4980B(f)(4) of the Code, except in the case of an Active Employee or Dependent whose self-payment eligibility period is increased from 18 to 29 months due to a disability, in which case the self-payment amount shall be no more than 150% of the

applicable premium for any month beginning after the 18th month of coverage and continuing through the end of the disability or the 29<sup>th</sup> month, whichever occurs earlier.

- D. **Maximum Number of Self-Payments.** The rights of an Active Employee and/or his/her eligible Dependents to continue coverage under this Section shall be continued until the end of the month in which the earliest of the following events occurs:
1. the Plan ceases providing any benefits to any participant;
  2. coverage ceases by reason of the failure of the Employee or Dependent to make timely self-payments required by the Trustees;
  3. the Employee and/or his eligible Dependents become covered under Medicare or another group health plan that does not have a limitation or exclusion for any pre-existing condition of the Employee or Dependent (as the case may be);
  4. for the loss of coverage due to insufficient hours, except as provided in Subsection 4.04(D)(5) below, 18 months have passed since the loss of coverage. For all other losses of coverage, 36 months have passed since the loss of coverage. In the case of multiple qualifying events, however, in no event shall coverage be for more than 36 months from the date of the initial loss of coverage;
  5. in the case of a disability (within the meaning of Title II or XVIII of the Social Security Act as amended) of an Active Employee or Dependent at the time of the loss of coverage due to insufficient hours, the 18-month period in Subsection 4.04(D)(4) above shall be increased to 29 months, as long as the Employee or Dependent remains disabled (or, if shorter, until another event above occurs). In particular, the coverage under this Subsection 5 shall end as of the earliest of:
    - a. the last day of the month which includes the 30th day after the date of the final determination under Title II or XVIII of the Social Security Act as amended that the Employee or Dependent is no longer disabled;
    - b. 29 months after the loss of coverage;
    - c. the occurrence of an event referred to in Subsections 4.04(D)(1), 4.04(D)(2), or 4.04(D)(3); and
  6. in the case of an Employee who does not engage in Competitive Employment and maintains active membership in the Union, self-payments may be continued for an additional 18-month period at the rate established by the Trustees.
- E. **Termination of Self-Payments.** Once an Employee fails to make the required self-payment within the specified time or has made the maximum number of self-payments specified in Subsection 4.04(D), he/she shall no longer be permitted to make the self-payments described and must re-qualify for coverage under this Plan in accordance with Section 4.01.
- F. **Payment of Self-Payment Premium for Employee and Dependents.** Initial self-payment(s) retroactive to the date of loss of coverage must be paid no later than the 45th day after the date the Fund Office is notified of the person's election to make self-payments. Each subsequent self-payment is due on the first day of the month for which coverage is intended. Self-payments received at the Fund Office later than 30 days after the due date shall not be accepted, and rights to self-payments shall terminate. There will be a \$20.00 charge for any check returned for insufficient funds. **There shall be no waivers granted.**

- G. **Trustee Rights to Request Information.** The Board of Trustees reserves the right to request and receive from Employees and Dependents who are continuing coverage in accordance with this Section any pertinent information bearing on the eligibility of such persons for the benefits provided under the self-payment provisions of this Plan. The failure of any such person to promptly respond to the Trustees' request for such information may lead to the self-payment rights described herein being suspended or terminated at the discretion of the Trustees.
- H. **Self-Payment Employees Affected by Multiple Events.** Notwithstanding anything to the contrary, no person may enjoy any one continuous self-payment coverage extension under the Plan beyond 36 months from the end of the month in which the first event giving rise to self-payment rights with respect to that person occurred.
- I. **Notice Requirements for Qualified Beneficiaries.**
1. Notwithstanding any other Plan provision, a qualified beneficiary must notify the Plan Administrator or the Fund Office within 90 days of:
    - a. his or her divorce or legal separation;
    - b. his or her dependent ceasing to be eligible for coverage under the group health plan;
    - c. the occurrence of a second qualifying event; or
    - d. the Social Security Administration's determination that the qualified beneficiary is disabled in order to have his or her COBRA period extended for an additional 11 months.
  2. The notice to the Plan Administrator must contain:
    - a. identification of the Plan as the Plumbers and Pipefitters Local Union 344 Health and Welfare Plan;
    - b. the identity of the qualified beneficiary;
    - c. a description of the qualifying event, and
    - d. the date the qualifying event occurred.

The notice must be in writing and sent either by mail or by fax to the following address:

Trust Fund Administrative Office  
4337 Southwest 44<sup>th</sup>  
Oklahoma City, OK 73119  
Phone: (405) 682-4581  
Fax: (405) 682-4584

#### **Section 4.05. Self-Payment Provisions for Retired Employees.**

A. **Retiree Eligibility.**

1. An individual may, upon retirement, continue comprehensive medical, dental, vision, prescription drug, and health reimbursement account benefits under this Plan (for the avoidance of doubt, Retirees are not eligible for life insurance or AD&D benefits under this Plan) for himself or herself and his or her spouse, provided he/she:
  - a. was covered under this Plan on the date his/her retirement commenced;
  - b. has exhausted the hours in his or her Hour Bank Account;

- c. qualifies for an Early, Regular, or Disability Retirement Pension from the Plumbers and Pipefitters National Pension Plan (as those terms are defined under that plan);
- d. does not engage in Competitive Employment during any month for which a self-payment is made;
- e. has attained the age of 55; and
- f. is not eligible for Medicare.

An individual who meets these requirements is considered a "Retiree" and eligible for Retiree coverage under the Plan. Retiree coverage is effective as of the date all requirements specified above are met. If an Employee retires and stops working prior to exhausting all hours in the Employee's Hour Bank Account, the Employee may use the accumulated hours to make full or partial self-payments until exhausted but will not be eligible for Retiree coverage until the Hour Bank Account is exhausted.

- 2. A Dependent Child(ren) shall not be eligible for coverage as a Dependent of a Retiree.
  - 3. A Dependent Spouse shall be eligible to participate if not eligible for Medicare.
  - 4. Coverage for either a Retiree or his or her Spouse shall terminate upon Medicare eligibility.
  - 5. Retirees or their Spouses that qualify for a federal or state health insurance subsidy are not eligible if the subsidy is greater than the benefit provided by the Plan.
- B. Application for Benefits.** A Retiree must initially elect coverage for himself/herself or his/her spouse within 30 days after his/her retirement. A Retiree's failure to make application within the prescribed time limit shall automatically forfeit any possibility of future enrollment.
- C. Payment of the Self-Payment Amount.** The first self-payment must be made to the Fund Office no later than the first day of the month in which "active" eligibility terminates. Each subsequent payment must be received at the Fund Office by the 25th of the previous month for which coverage is intended.
- 1. In the event self-payments are being made in the form of automatic withdrawal from a Retiree's or Spouse's checking account, such transactions are completed on or about the 25th day of the month prior to the month for which coverage is intended.
  - 2. If a Retired Employee fails to make the required self-payment for one month, he/she may apply to the Fund Office for reinstatement with Trustee approval.
  - 3. Under no circumstances shall payment be accepted if more than 2 months' self-payments are due. There will be a \$20.00 charge for any check returned for insufficient funds. **There shall be no waivers granted.**

**Section 4.06. Eligibility Rules for Dependents.** An individual shall be eligible for Plan benefits provided to Dependents during any period the individual qualifies as a Dependent in accordance with the following provisions:

- A. **Effective Date of Coverage.** With respect to married Employees and notwithstanding the following, a Dependent's coverage shall become effective on the date the Dependent becomes eligible for coverage, provided the Employee is eligible. With respect to unmarried Employees, newly acquired Dependents become eligible within 60 days following the marriage.

Acceptable proof of marriage is required by the Trustees. Such proof may be a copy of the marriage license or the Plan's common-law questionnaire, attesting to the date of marriage. In

the event of a divorce, a copy of the divorce decree is required. In the event of a remarriage, a copy of both party's divorce decrees is required.

- B. **Termination of Coverage.** Coverage for a Dependent shall cease on the earlier of the date the Employee's eligibility ends or the date the Dependent no longer meets the definition of Dependent.

However, if a Dependent's eligibility for Plan benefits is lost solely due to the death of an Active Employee, the surviving Dependents may continue to participate in comprehensive medical, dental, and vision benefits (provided that the Dependent does not become covered under another group health plan as an Employee or a Dependent unless such other plan contains an exclusion or limitation for any pre-existing condition of such Dependent) without making self-payments for as long as the Active Employee's Hour Bank Account contains a sufficient balance for coverage as would otherwise be required under this Article 4 had the Dependents not lost coverage due to the death of the Active Employee. After the Hour Bank Account is depleted, the surviving Dependents may continue to participate in the comprehensive medical, dental, and vision benefits by making monthly self-payments.

- C. **Limitation on Prescription Drug Benefits for Certain Dependent Spouses.** A Dependent who is the Spouse of an Active Employee and who has prescription drug benefit coverage under another employer-sponsored group health plan is not eligible for the prescription drug benefits under Article 9 of this Plan.

#### **Section 4.07. Dependent Eligibility and Enrollment.**

- A. **Eligibility Requirements.** To become eligible to participate in the Plan:
1. The Dependent must satisfy the definition of "Dependent" in the Glossary; and
  2. The Employee must apply for and be enrolled in the Plan in order to obtain Dependent coverage.
- B. **Initial Enrollment.** If a Participant enrolls a Dependent within 90 days of the date of hire, the Dependent's Effective Date shall be the same day as the Participant's Effective Date. If an eligible Dependent fails to enroll within 90 days from the date of hire or within 90 days of becoming eligible for coverage, such Dependent must wait until the next Open Enrollment Period to enroll and shall be deemed a Late Enrollee.

#### **Section 4.08. Special Enrollees.**

- A. **Later-Acquired Dependent.** If the Participant has no eligible Dependents during the initial enrollment period, but later acquires an eligible Dependent (which was not previously a Dependent of the Participant), the Participant may complete, sign and return an application to the Plan Administrator within the time period specified below after acquiring the new Dependent. If the newly acquired Dependent(s) is enrolled within this period, the Effective Date of the Dependent's coverage is the first date the Dependent met the definition of Dependent.
1. **Newborn or Adopted Children.** Newborn and newly-adopted children shall be covered for Illness or Injury from the moment of birth, adoption or placement for adoption. Covered Expenses **include** the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent within 90 days of the child's date of birth or adoption or placement for adoption. This provision shall not apply to or in any way affect the maternity coverage applicable to the mother. If the

Dependent is not enrolled within 90 days of becoming eligible, he or she is considered to be a Late Enrollee.

**Actual Enrollment is Necessary Upon Birth of Newborn or Placement for Adoption.**

Please be aware it is necessary to obtain, complete, sign and return a **new enrollment form** to add a newborn or adopted child to the Plan. If the Participant fails to complete, sign and return an enrollment form within 90 days after the birth of a newborn, adoption or placement for adoption, the Dependent **will not have coverage** or be able to enroll until the next Open Enrollment Period.

Claims for maternity expenses or maternity leave **do not** constitute notification or enrollment of a new Dependent for Coverage.

2. **Spouse Upon Marriage.** A spouse will be considered an eligible Dependent from the first day of the month following the date of marriage or date of common law marriage, provided the spouse is properly enrolled as a Dependent within 60 days of the date of marriage.
  3. **Court Order or Decree.** If a Dependent is acquired through marriage (i.e. step children), that Dependent will be considered a Dependent from the date of such marriage, provided that this new Dependent is properly enrolled as a Dependent within 60 days of the court order, decree, or marriage.
- B. **Qualified Medical Child Support Order.** A child may become eligible for coverage as set forth in a Qualified Medical Child Support Order. The Plan Administrator will establish written procedures for determining (and have sole discretion to determine) whether a medical child support order is qualified and for administering the provisions of the benefit under the Plan pursuant to a Qualified Medical Child Support Order. Covered Persons may request a copy of the Plan's written procedures from the Plan Administrator, free of charge. The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order.
- C. **Loss of Alternate Health Coverage.** A Participant or a Dependent who was previously eligible for coverage, but did not enroll because of alternate health coverage, may complete, sign and return an application to the Plan Administrator within the 31-day Special Enrollment period following the Participant or Dependent's loss of such other coverage due to any of the following:
- a. Exhaustion of COBRA Continuation Coverage;
  - b. Loss of eligibility for such other coverage due to divorce, legal separation, death, termination of employment or reduction of hours of employment; or
  - c. Termination of Employer Contributions.

Individuals who lose coverage due to nonpayment of premiums or for cause (e.g. filing fraudulent claims) shall not be Special Enrollees hereunder. Coverage for a Special Enrollee hereunder shall begin as of the first day of the calendar month following the enrollment request.

- D. **Special Enrollment Based on Children's Health Insurance Program (CHIP).** Employees and Dependents who are eligible but not enrolled for coverage when initially eligible may become a Special Enrollee in two additional circumstances:

1. The Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
  2. The Employee or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the Employee requests coverage under the Plan within 60 days after eligibility is determined.
- E. **Late Enrollees.** Late Enrollees may enroll in the Plan during the Open Enrollment Period as set forth in the Open Enrollment subsection below. The Effective Date of the Late Enrollee's coverage is the first day of the Plan Year following enrollment.

**Section 4.09. Dependent's Termination of Participation.**

- A. A Dependent's participation under the Plan shall terminate on the earlier of the following occurrences:
1. With respect to Dependents of Employees other than Non-Bargaining Employees, the date the Participant's Hour Bank has insufficient hours;
  2. The date on which the Participant or the Dependent loses his status as a Covered Person(s);
  3. The date the Plan terminates for any or no reason with or without advance notice;
  4. While on an Approved Leave of Absence, the Participant becomes employed full time by another employer and is eligible for health benefits;
  5. The failure to pay required Contributions. In such case, coverage shall terminate on the last date for which the required Contributions were paid, as determined by the Plan Administrator;
  6. Upon a Participant's death, any Covered Dependent may remain a Dependent for the applicable period of Continuation Coverage set forth in the Continuation Coverage Section, provided that the Covered Dependent complies with the conditions therein; or
  7. For cause (e.g. filing fraudulent claims and/or misuse of identification card or benefits).
  8. With respect to Dependents of Non-Bargaining Employees, the Non-Bargaining Employee's termination of employment.
- B. Additionally, a Dependent may voluntarily drop coverage at any time during the Plan Year.

**Section 4.10. Open Enrollment.** The Plan shall conduct an Open Enrollment each Calendar Year. The Open Enrollment Period shall run for a period defined each year as determined by the Plan Sponsor. During Open Enrollment, Participants may make any of the following changes regarding participation in the Plan, subject to the other governing provisions of this Plan Document:

- A. Enroll as a Late Enrollee;
- B. Add Dependents not able to enroll during the Calendar Year as Special Enrollees; and
- C. Make such other changes as permitted by this Plan document.

**Section 4.11. Retiree Subsidy.**

- A. Retirees shall be entitled to a 35% subsidy funded by the active member hourly required health and welfare contribution rate set by the collective bargaining agreement. The subsidy rate adjustment shall be based on estimated man hours or actual hours worked the previous year.
- B. Retirees shall be entitled to a second subsidy in addition to the above. The additional subsidy will be funded by the active members equal to twenty cents (\$0.20) per man hour. The subsidy rate shall be based on estimated hours or actual hours worked the previous year.



## ARTICLE 5 CONTINUATION OF COVERAGE

Federal law, through passage of COBRA, created the right to a temporary extension of group health coverage under the Plan in certain circumstances when coverage would otherwise end. COBRA Continuation Coverage can apply to Qualified Beneficiaries when such persons would otherwise lose group health coverage under the Plan. A "Qualified Beneficiary" is an individual who was covered by the Plan on the day before a Qualifying Event occurred that caused him or her to lose coverage. A Qualified Beneficiary must be a Participant or Dependent under the Plan. The following explains COBRA Continuation Coverage, when it may become available and how to protect the right to receive COBRA.

For additional information about rights and obligations under the Plan and under federal law, contact the Plan Administrator which administers COBRA for the Plan.

**Section 5.01. COBRA Continuation Coverage.** COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." For COBRA to apply, the Qualifying Event must cause a loss of coverage under the Plan.

- A. **COBRA Qualifying Events for Participants.** A Participant may elect COBRA Continuation Coverage, at the Participant's own expense, if participation under the Plan terminates as the result of a Qualifying Event. Qualifying Events for Participants include termination of employment, either voluntary or involuntary, or a reduction in hours of employment. COBRA Continuation Coverage will not be offered when the termination of employment was due to the Participant's gross misconduct.
- B. **COBRA Qualifying Events for Dependents.** A Dependent may elect COBRA Continuation Coverage, at the Dependent's own expense, if the Dependent's participation under the Plan terminates as the result of a Qualifying Event. Qualifying Events for Dependents include the following:
  - 1. Death of the Participant;
  - 2. The Participant's loss of employment, either voluntary or involuntary, unless caused by the Participant's gross misconduct;
  - 3. An insufficient number of hours in the Participant's Hour Bank;
  - 4. A Participant becomes entitled to Medicare;
  - 5. Divorce or legal separation from the Participant. (If a Participant cancels coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the divorce or legal separation and can establish that the Participant cancelled the coverage earlier in anticipation of the divorce or legal separation, then COBRA Continuation Coverage may be available for the period after the divorce or legal separation);  
or
  - 6. A Dependent Child ceases to qualify as a Dependent under the Plan.
- C. **Other Qualified Beneficiaries.** Other individuals who may be COBRA Qualified Beneficiaries include:
  - 1. **Recipients under Qualified Medical Child Support Orders.** A child of the Participant who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order received by the Plan Administrator during the Participant's period of employment is entitled

to the same rights under COBRA as a Dependent child of the Participant, regardless of whether that child would otherwise be considered a Dependent.

2. **Birth or Adoption.** A child born to, adopted by, or placed for adoption with a Participant during a period of Continuation Coverage is considered to be a Qualified Beneficiary provided that the Participant has elected Continuation Coverage for himself or herself. The child's COBRA Continuation Coverage begins when the child is enrolled in the Plan, whether through Special Enrollment or Open Enrollment, and it lasts for as long as COBRA Continuation Coverage lasts for other Family members of the Participant. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan requirements.
3. **Participants and Dependents after FMLA.** If a Participant takes FMLA leave and does not return to work at the end of the leave, the Participant and any Dependents will be entitled to elect COBRA if:
  - a. They were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and
  - b. They will lose Plan coverage within 18 months because of the Participant's failure to return to work at the end of the leave.

COBRA Continuation Coverage elected in these circumstances will begin on the last day of the FMLA leave.

COBRA Continuation Coverage is the same coverage that the Plan gives to other Participants and their Dependents under the Plan that are not receiving COBRA Continuation Coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Participants or Dependents covered under the Plan, including open enrollment and Special Enrollment rights.

**D. Duty to Notify Plan Administrator of Qualifying Events.**

1. The Employer must notify the Plan Administrator within 30 days of one of the following Qualifying Events:
  - a. The Participant's loss of employment, either voluntary or involuntary;
  - b. A reduction in the Participant's hours of employment;
  - c. Death of the Participant;
  - d. Participant becoming entitled to Medicare; or
  - e. Bankruptcy of the Employer.
2. In order to be eligible for COBRA Continuation Coverage, the **Participant or Dependent must notify the Plan Administrator**, in writing, within 60 days of one of the following Qualifying Events:
  - a. Divorce;
  - b. Legal Separation; or
  - c. A Dependent child ceases to qualify as a Dependent under the Plan.
3. If the Participant or Dependent provides a written notice that does not contain all of the information and documentation required, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- a. Notice is mailed or hand delivered by the deadline;
- b. From the notice, the Plan Administrator is able to determine the identity of the Employer, Participant and Qualified Beneficiaries, and the Qualifying Event; and
- c. The notice is supplemented with the additional information and documentation to meet the Plan's requirements within 15 business days after a written or oral request from the Plan Administrator requesting more information.

If any of these conditions are not met, the incomplete notice will be rejected and **COBRA Continuation Coverage will not be offered.**

**Caution:** If these procedures are not followed or if written notice is not provided to the Plan Administrator within the specified time period, any Participant or Dependent who loses coverage will not be offered the option to elect Continuation Coverage.

**Notice Procedures:** Any notice provided must be in writing. Oral notice, including notice by telephone or e-mail, is not accepted. The notice must be mailed or hand-delivered to the Plan Administrator at this address:

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must:

- Name the Qualifying Event and the date it occurred;
- State the name of the Plan (benefits program);
- State the name and address of the Participant covered under the Plan; and
- State the name(s) and address(es) of any Dependent(s) who lost coverage.

If the Qualifying Event is a divorce, your notice must include a copy of the divorce decree.

Your notice of a second Qualifying Event must also include the above listed information.

Your notice of disability must also include the name of the disabled qualified Dependent, the date when the Dependent became disabled, the date the Social Security Administration made its determination, and a statement as to whether or not the Social Security Administration has subsequently determined that the Qualified Beneficiary is no longer disabled. Your notice of disability must include a copy of the Social Security Administration's determination.

**E. Electing COBRA Continuation Coverage.** The following rules apply to COBRA election:

1. COBRA Continuation Coverage will begin on the date of the Qualifying Event for each Qualified Beneficiary who timely elects COBRA Continuation Coverage.
2. Each Qualified Beneficiary has an independent right to elect Continuation Coverage.
3. A Qualified Beneficiary must elect coverage in writing within 60 days of being provided a COBRA Election Notice, using the Plan's election form and following the procedures specified on the election form.
4. Written notice of election must be provided to the Plan Administrator at the address provided on the Plan's election form. If mailed, the election form must be postmarked no later than the last day of the 60-day election period.

5. An affirmative election of COBRA Continuation Coverage by a Participant shall be deemed to be an election for that Participant's Dependents who would otherwise lose coverage under the Plan.
6. A Participant or Dependent may change a prior rejection of Continuation Coverage at any time during the 60-day period by providing the written notice of election above; however, once a Participant or Dependent makes an initial rejection of Continuation Coverage and then changes that prior rejection, such coverage is not retroactive to the date of the initial loss of coverage, but only to the date of election.
7. Failure to elect Continuation Coverage within the 60-day election period will terminate all rights to COBRA Continuation Coverage.

The Participant (i.e. the Employee or former Employee who is or was covered under the Plan), Dependent, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy the responsibility to provide notice on behalf of all Qualified Beneficiaries who lost coverage due to the Qualifying Event described in the notice.

**Note Regarding Effect of Failure to Elect.** In considering whether to elect Continuation Coverage, you should take into account that a failure to continue group health coverage will affect your future rights under federal law.

You should take into account that you have Special Enrollment rights under federal law. You have the right to request Special Enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the Qualifying Event listed above. You will also have the same Special Enrollment right at the end of Continuation Coverage if you get Continuation Coverage for the maximum time available to you.

- F. **Length of Continuation Coverage.** COBRA Continuation Coverage is a temporary continuation of coverage. The COBRA Continuation Coverage periods described below are maximum coverage periods.

1. **Period of Continuation Coverage for Participants.** A Participant who qualifies for COBRA Continuation Coverage as a result of termination of employment or reduction in hours of employment described above, may elect COBRA Continuation Coverage for up to 18 months measured from the date of the Qualifying Event. Coverage under this Section may not continue beyond:

- a. The date on which the Employer ceases to maintain a group health plan;
- b. The last day of the month for which the required Contributions have been made;
- c. The date the Participant becomes entitled to Medicare; or
- d. The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health plan that is not maintained by the Employer.

COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Dependent not receiving COBRA Continuation Coverage (such as fraud).

2. **Period of COBRA Continuation Coverage for Dependents.** If a Dependent elects COBRA Continuation Coverage under the Plan as a result of the Participant's termination of employment or reduction in hours of employment as described above, Continuation Coverage

may be continued for up to 18 months measured from the date of the Qualifying Event. COBRA Continuation Coverage for all other Qualifying Events may continue for up to 36 months. In addition to maximum periods discussed immediately above, Continuation Coverage under this Subsection may not continue beyond:

- a. The last day of the month for which required Contributions have been made;
  - b. The date the Dependent becomes entitled to Medicare;
  - c. The date on which the Employer ceases to maintain a group health plan; or
  - d. The first day after the COBRA Continuation Coverage election, when the Dependent is covered under any other group health plan that is not maintained by the Employer.
3. **Other Termination.** COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or Dependent not receiving COBRA Continuation Coverage (such as fraud).
4. **Second Qualifying Events.** If during an 18-month maximum period of Continuation Coverage, a Qualified Beneficiary experiences a second Qualifying Event that is the death of a Participant, the divorce or legal separation from a Participant, a Participant becoming enrolled in Medicare, or a Dependent child ceasing to be eligible for coverage as a Dependent under the Plan, coverage may be continued for a maximum of 36 months from the date of the first Qualifying Event. The Qualified Beneficiary must notify the Plan Administrator within 60 days after the second Qualifying Event using the Notice Procedures in the box in Section 5.01(D). (This extension is not available under the Plan when a Covered Participant becomes entitled to Medicare). **Failure to provide timely notice of a second Qualifying Event will result in non-extension of COBRA Continuation Coverage.**
5. **Medicare or Other Group Health Coverage.** Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA Continuation Coverage will not terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage.

**Note:** You must notify the Plan Administrator if any Qualified Beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare Entitlement.

6. **Extension of COBRA Continuation Period for Disabled Qualified Beneficiaries.**
- a. The period of Continuation Coverage shall be extended to 29 months (measured from the date of the initial Qualifying Event) in the event:
    - (i) The Qualified Beneficiary is disabled (as determined by the Social Security laws) within 60 days after the date of the Qualifying Event; and
    - (ii) The Qualified Beneficiary provides evidence to the Plan Administrator or its authorized representative of such Social Security Administration determination prior to the earlier of 60 days after the date of the Social Security Administration determination, or the expiration of the initial 18 months of COBRA Continuation Coverage.
  - b. In such event, the Plan may charge the Qualified Beneficiary up to 150% of the COBRA cost of the coverage for all months after the 18th month of COBRA coverage, so long

as the disabled Qualified Beneficiary is in the covered group. The Qualified Beneficiary must notify the Plan Administrator if he or she is deemed no longer disabled, in which case COBRA Continuation Coverage ends as of the first day of the month that is more than 30 days after the Social Security Administration determination.

**G. Cost of COBRA Continuation Coverage.**

1. **Amount.** Each Qualified Beneficiary may be required to pay the entire cost of Continuation Coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both Employer and Participant Contributions) for coverage of a similarly situated Plan Participant or Dependent who is not receiving Continuation Coverage, (or in the case of an extension of Continuation Coverage due to a disability, 150%).
2. **Timely Payment of Premiums.** Participants and Dependents who elect COBRA Continuation Coverage as a result of one of the Qualifying Events specified above must make Continuation Coverage payments.

Participants and Dependents must make the Continuation Coverage payment monthly prior to the first day of the month in which such coverage will take effect. However, a Participant or Dependent has 45 days from the date of an affirmative election to pay the Continuation Coverage payment for the period between the date medical coverage would otherwise have terminated due to the Qualifying Event and the date the Participant and/or Dependent actually elects COBRA Continuation Coverage, and for the first month's coverage. The Participant and/or Dependent shall have a 31-day grace period to make the Continuation Coverage payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the 31-day grace period. If Continuation Coverage payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which required Contributions were made. The 31-day grace period shall not apply to the 45-day period for payment of COBRA premiums as set out in this Subsection.

3. **Trade Act of 2002.** Two provisions under the Trade Act affect benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. Participants should consult the Plan Administrator if he or she believes the Trade Act applies to their situation.

**Notice Regarding Individual Policies.** The Health Insurance Portability and Accountability Act ("HIPAA") requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a Preexisting Condition exclusion. To take advantage of this HIPAA right, you must elect Continuation Coverage under the Plan and pay the required contribution for the duration of your 18-, 29-, or 36-month Continuation Coverage. You must then apply for coverage with an individual insurance carrier before you have a Significant Break in Coverage.

## Section 5.02. USERRA Coverage.

**You Have Rights Under Both COBRA and USERRA.** Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA. COBRA and USERRA will both apply with respect to the Continuation Coverage elected. If COBRA or USERRA give you or your Covered Dependents different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures for COBRA also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) established requirements that employers must meet for certain employees who are involved in the Uniformed Services. In addition to rights under COBRA, Qualified Beneficiaries are entitled under USERRA to continue the coverage of Participants and Covered Dependents under the Plan.

“Uniformed Services” means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full time National Guard duty pursuant to orders issued under federal law, and the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of war or national emergency.

Service in the Uniformed Services or Service means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty, the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain duty and training by intermittent disaster response personnel of the National Disaster Medical System.

### A. Duration of USERRA Coverage.

1. **General Rule.** When a Participant takes a leave for service in the Uniformed Services, USERRA coverage for the Participant (and Covered Dependents for whom coverage is elected) begins the day after the Participant (and Covered Dependents) loses coverage under the Plan, and it may continue for up to 24 months. However, USERRA coverage will end earlier if one of the following events takes place:
  - a. Failure to give advance notice of service;
  - b. Failure to make a premium payment within the required time;
  - c. Failure to return to work within the time required under USERRA (see below) following the completion of service in the Uniformed Services; or
  - d. Losing rights under USERRA as a result of a dishonorable discharge or other undesirable conduct specified in USERRA.
2. **Returning to Work.** The right to continue coverage under USERRA will end if a Participant does not notify his or her employer of the intent to return to work within the time required under USERRA following the completion of service in the Uniformed Services by either reporting to work (when absence was for less than 31 days) or applying for reemployment (if absence was for more than 30 days). The time for returning to work depends on the length of the absence, as follows:

<b>Period of Absence</b>	<b>Return to Work Requirement</b>
Less than 31 days	Report to work at the beginning of the first regularly scheduled work period following the end of service plus 8 hours or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
More than 30 days but less than 181 days	Submit an application for employment not later than 14 days after the completion of the service, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
More than 180 days	Submit an application for employment not later than 90 days after the completion of the service.
Any period, if the absence was for purposes of an examination for fitness to perform service	Report to work at the beginning of the first regularly-scheduled work period following the end of service plus 8 hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
Any period if the Employee was hospitalized for or is convalescing from an illness or Injury Incurred or aggravated as a result of the Employee's service	Apply for work or submit application as described above (depending on length of absence) when recovery is over, but recovery time is limited to two years. The 2-year period is extended by any minimum time required to accommodate circumstances beyond the Employee's control that make compliance with these deadlines unreasonable or impossible.

- B. **Concurrent.** COBRA coverage and USERRA coverage begin at the same time and run concurrently. However, COBRA coverage can continue longer, depending on the Qualifying Event, and is subject to different early termination provisions. In contrast, USERRA coverage can continue for up to 24 months, as described earlier in this Article.
- C. **Premium Payments for USERRA Continuation Coverage.** If a Participant or Covered Dependent elects to continue health coverage pursuant to USERRA, the Participant will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if the Participant's Uniformed Services leave of absence is less than 31 days, the Participant is not required to pay more than the amount that such Participant pays as an active Employee for that coverage.

**Section 5.03. Family and Medical Leave Act.**

- A. If a non-bargained Participant is on a Family or Medical Leave of Absence, the Participant may continue coverage in accordance with the Family and Medical Leave Act of 1993 ("FMLA"), and the Plan will continue coverage, as if the Participant was Actively at Work if the following conditions are met:
  - 1. The required Contribution is paid; and
  - 2. The Participant has written approval of leave from the Employer.
- B. Coverage will be continued for up to the greater of:
  - 1. The leave period required by the Family and Medical Leave Act of 1993 and any amendments thereto or regulations promulgated thereunder; or
  - 2. The leave period required by applicable state law.



- C. If coverage is not continued during a family or medical leave of absence, when the Participant returns to Actively at Work status, then no new Waiting Period will apply.

## ARTICLE 6 COST CONTAINMENT FEATURES

### Section 6.01. Preferred Provider Organization.

The Plan Administrator has entered into an agreement with one or more networks of hospitals, physicians, or other providers and facilities called who are In-Network. These In-Network providers offer Covered Persons health care services at discounted rates. Using an In-Network provider will normally result in a lower cost to the Plan as well as to the Covered Person. In no event shall an In-Network provider or an Out-of-Network provider be paid more by the Plan than the amount deemed by the Plan Administrator to be within the Applicable Plan Limit.

This Plan utilizes United Healthcare (“UHC”) as the Preferred Provider Network. UHC is a network of Hospitals, Physicians and other healthcare providers and facilities that have agreed to accept set fees for providing medical services to Covered Persons if such Covered Person chooses to use them.

Contractual arrangements entered into by the Plan are intended to be for the exclusive benefit of the Plan and its eligible Participants and Dependents. If the Plan Administrator, in its capacity as a Fiduciary of the Plan and in accordance with ERISA, determines, in its sole discretion, the contractual arrangements are not in the best interest of the Plan or violate applicable laws, the Plan Administrator shall pay benefits in accordance with its Fiduciary duties regardless of any contractual arrangements to the contrary. Similarly, under ERISA §404(d), if any Plan documents, in the Plan Administrator’s sole discretion, contain provisions that are inconsistent with ERISA, including ERISA’s Fiduciary duties, the Plan Administrator is released from its obligation to administer the Plan in accordance with the conflicting provision.

Some In-Network Provider Hospitals may have arrangements through which the benefit payable is more than the actual charges, e.g., per diem or diagnosis-related group (“DRG”) charges. When this occurs, the Plan will pay the PPO Network Provider Hospitals’ per diem or DRG rates; not to exceed the Applicable Plan Limit for such services, as determined by the Plan Administrator regardless of any contractual arrangement to the contrary.

A current list of In-Network providers is available, without charge, through the website located at [www.uhc.com](http://www.uhc.com). Covered Persons may also contact the Network at the phone number on the Plan ID card.

### Section 6.02. Inpatient Precertification.

Precertification is the process of collecting information prior to inpatient admissions (including but not limited to acute care, maternity services, inpatient rehab, etc.) to confirm that a Physician’s plan of treatment meets the Medically Necessary standard under the Plan.

Covered Persons are responsible for satisfying the requirements for precertification. For an inpatient facility stay, a Covered Person must request precertification from Medical Management before the scheduled admission. Medical Management will consult with your Physician, Hospital, or other facility to determine if inpatient level of care is required for your illness or injury. Medical Management may decide that the treatment could be provided just as effectively in a less expensive setting (such as the outpatient department of a Hospital, an ambulatory surgical facility, or a Physician’s office). If Medical Management determines that treatment does not require inpatient care, the Covered Person and his/her Provider will be notified of that decision. If a Covered Person proceeds with an inpatient stay without Medical Management’s approval, or if the Covered Person does not ask Medical Management for precertification, benefits under the Plan will be reduced as described below under “Failure to Precertify,” provided Medical Management determines that benefits are payable upon receipt of a claim. This reduction applies in addition to any benefit reduction associated with the use of an Out-of-Network Provider.

- A. **Failure to Precertify.** Except in cases of Excepted Services as described below, if a Covered Person does not call for precertification for an inpatient service or treatment, the admission will be subject to a \$250 reduction in benefits, if upon receipt of the claim, Medical Management determines that the services were Medically Necessary. If Medical Management determines that the services were not Medically Necessary, the Covered Person may be responsible for payment of the full cost of services received.
- B. **Excepted Services.** Covered Persons shall not be required to obtain precertification for the following services:
  - 1. Emergency Services, including the medical screening, treatment, and care pertaining to an Emergency Medical Condition (as defined in the Glossary) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition.
  - 2. Obstetrical or gynecological services provided by a participating health care professional who specializes in obstetrics or gynecology.
  - 3. Inpatient maternity admission which does not exceed a 48-hour (for vaginal delivery) or 96-hour (for cesarean delivery) Hospital stay.
- C. **How to Precertify.**
  - 1. To precertify inpatient services, Covered Persons should call Medical Management at 1-800-433-3232 or call 1-800-422-3342 for eligibility. Upon verification of eligibility and benefits, Covered Persons will be advised on how to proceed.
  - 2. Providers registered with Availity® or RealMed® may submit online precertification and authorization requests and inquiries on behalf of a Covered Person, but it will be the responsibility of the Covered Person to ensure inpatient services are precertified prior to receipt of such services.

**ARTICLE 7 COVERED MEDICAL EXPENSES**

**Section 7.01. Major Medical Benefit.** The major medical benefits provided under this Plan cover a wide range of services referred to as Covered Expenses. The services associated with this benefit are covered to the extent that they are:

- A. Medically Necessary;
- B. Prescribed by or given by a Physician;
- C. Within the Applicable Plan Limit; and
- D. Provided for care and treatment of a covered Illness or Injury.

Covered benefits are payable to the extent set forth in the Schedule of Benefits.

**Section 7.02. Listed Covered Expenses.**

The Plan shall not pay for any service, procedure or supply Incurred by the Covered Person, unless it is specifically listed as a Covered Expense under this Article 7. Covered Expenses are the services listed below. All Covered Expenses are subject to the limitations and exclusions set forth in Article 8 and all other provisions of this Plan, and payable only to the extent set forth in the Schedule of Benefits:

<b>Allergy Services</b>	Allergy testing, treatment, serum and injections will be payable as shown in the Schedule of Benefits.
<b>Ambulance Service</b>	Hospital or licensed ambulance or air ambulance service when Medically Necessary for transportation to a local Hospital or to the nearest Hospital. Also included is a transfer to the nearest facility equipped to treat the emergency and from a Hospital to the Covered Person’s home.
<b>Ambulatory Surgical Facility</b>	Services and supplies furnished by an Ambulatory Surgical Facility.
<b>Anesthetics</b>	Anesthetics and their professional administration.
<b>Attention Deficit Disorders</b>	Medically necessary treatment for Attention Deficit Disorders and related behavioral disorders. Prescriptions shall be covered under the Prescription Drug Benefit.
<b>Blood Plasma</b>	Services and supplies required for the administration of blood transfusions, including blood, Blood Plasma, and plasma expanders, when not available to the Covered Person without charge.
<b>Bone Mass Measurement</b>	Coverage for scientifically proven and approved Bone Mass Measurement in the diagnosis and evaluation of osteoporosis or low bone mass.  Such coverage provided if: <ul style="list-style-type: none"> <li>1. At least 23 months have elapsed since the previous Bone Mass Measurement was performed; or</li> <li>2. If Medically Necessary, more frequent Bone Mass Measurement are covered and may include but are not limited to: <ul style="list-style-type: none"> <li>a. Monitoring Covered Persons on long-term gluco-corticoid therapy for more than 3 months; and</li> <li>b. Allowing for a central Bone Mass Measurement to determine the effectiveness of adding on additional treatment regimens for a Covered Person who is proven to</li> </ul> </li> </ul>

	have low bone mass as long as the Bone Mass Measurement is performed 12 to 18 months from the start date of the additional regimen.
<b>Cancer Drug Treatment</b>	Coverage of a drug for the treatment of cancer cannot be denied on the basis that the drug has not been approved by the Food and Drug Administration, for the treatment of a specific type of cancer for which such drug was prescribed, provided that such drug is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia, (1) The U.S. Pharmacopoeia Drug Information Guide for the Health Care Professional (USP DI); (2) the American Medical Association's Drug Evaluation (AMA DE); or (3) the American Social Hospital Pharmacists' American hospital Formulary Service Drug Information (AHFS-DI).
<b>Cervical Cancer Screening</b>	Examinations and laboratory tests for the screening for early detection of cervical cancer including: pap smear screening, liquid based cytology and Human Papilloma Virus ("HPV") detection methods for female Participants and Dependents with equivocal findings on cervical cytologic analysis that have been approved by the United States Food and Drug Administration.
<b>Chiropractic Treatment</b>	See Spinal Manipulation Treatment.
<b>Cleft Lip and Related Conditions</b>	Inpatient and Outpatient dental, oral surgical and orthodontic services which are Medically Necessary for the treatment of cleft lip, cleft palate or ectodermal dysplasia.
<b>Clinical Trials</b>	<p>Covered expenses include charges made for routine patient services associated with clinical trials approved and sponsored by the federal government for the treatment of cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.</p> <p>In addition the following criteria must be met:</p> <p>The clinical trial for the treatment of cancer or other life-threatening disease or condition is registered on the NIH maintained web site <a href="http://www.clinicaltrials.gov">www.clinicaltrials.gov</a> as a Phase I, II, III, or IV clinical trial.</p> <p>The Covered Person meets all inclusion criteria for the clinical trial and is not treated "Off-Protocol", as defined in the Glossary Article of the Plan.</p> <p>The Covered Person has signed an informed consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed informed consent;</p> <p>The trial is approved by the institutional review board of the institution administering the treatment.</p> <p>Routine patient services will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Covered Person would receive whether or not he or she were participating in a clinical trial.</p> <p><b><i>Routine patient services do not include, and reimbursement will not be provided for:</i></b></p> <ol style="list-style-type: none"> <li>1. The investigational service, supply, or drug itself;</li> <li>2. Services or supplies listed under the Limitations and Exclusions section of the Plan;</li> </ol>

	<ol style="list-style-type: none"> <li>3. Services or supplies related to data collection for the clinical trial (i.e., Protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Covered Person (e.g. monthly CT scans for a condition usually requiring only a single scan); and</li> <li>4. Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g. device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.”</li> </ol>
<b>Colorectal Cancer Screening</b>	Unless otherwise covered under Preventive Health Services, Colorectal cancer screening will be covered as any other Illness. Covered procedures not otherwise covered under Preventive Health Services include: medically recognized screening, specialty screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances, radiologic imaging, as provided in accordance with U.S. Preventive Services Task Force (“USPSTF”) guidelines.
<b>Contact Lenses After Cataract Surgery</b>	Initial purchase of contact lenses and/or eyeglasses if required as a result of cataract surgery shall be a Covered Expense under the Health Plan.
<b>Contraceptives</b>	Any Prescription device other than oral contraceptives approved by the United States Food and Drug Administration for use as a female contraceptive, including implants, intrauterine devices, prescription barrier methods, and procedures. Oral contraceptives are covered under the Prescription Drug Program.
<b>Craniofacial Abnormalities</b>	For children younger than 18 years of age, reconstructive surgery for craniofacial abnormalities, meaning surgery to improve function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disorder.
<b>Dental Care</b>	Medical expenses for dental care shall include coverage for Medically Necessary general anesthesia and related hospitalization charges. The Covered Person must be: <ol style="list-style-type: none"> <li>1. Under the age of 8 years old and determined by a licensed Dentist, in conjunction with a licensed Physician, to have a dental condition of significant dental complexity that requires certain dental procedures to be performed in a Hospital; or</li> <li>2. Developmentally disabled and care outside of a Hospital environment would place the person at serious risk; or</li> <li>3. Suffering from severe Disability as determined by a licensed Provider.</li> </ol>
<b>Diabetic Care</b>	Office visits and consultations with Physicians and practitioners as Medically Necessary for the diagnosis and treatment of diabetes.
<b>Diabetic Supplies and Education</b>	<p>Insulin, insulin pumps, test strips, needles, syringes and related supplies if not covered by the Prescription Drug Program in Article 9, podiatric appliances including up to one pair of therapeutic footwear and glucagon emergency kits.</p> <p>Self-management training upon initial diagnosis of diabetes, or upon written order of a Physician or practitioner that:</p> <ol style="list-style-type: none"> <li>1. A significant change in condition requires change in self-management regimen; or</li> <li>2. Continuing education is warranted by development of new techniques and treatment.</li> </ol>

	<p>Such self-management training includes a program:</p> <ol style="list-style-type: none"> <li>1. Recognized by the American Diabetes Association;</li> <li>2. Provided by an educator certified by the National Certification Board for Diabetes Association; or</li> <li>3. From other providers qualified under state law.</li> </ol>
<b>Diagnostic Charges</b>	X-ray, laboratory services, diagnostic charges and Preadmission testing. See Schedule of Benefits.
<b>Dietitians</b>	Services of a licensed dietitian within the scope of licensure if related to Illness or Injury covered by the Plan and if recommended by a Physician in connection with an examination or treatment covered by the Plan.
<b>Durable Medical Equipment</b>	The lesser of the rental or purchase price of Medically Necessary Durable Medical Equipment, subject to the percentage shown in the Schedule of Benefits and other applicable limits.
<b>Emergency Services</b>	Emergency services to the extent necessary to screen and stabilize the Participant. Precertification is not required if a prudent layperson acting reasonably would believe that an Emergency Medical Condition existed.
<b>External Prosthetics</b>	Artificial prosthetics when Medically Necessary for Activities of Daily Living for the alleviation of or correction of conditions arising out of an Illness or Injury, including repair, maintenance and replacement when Medically Necessary. Benefits for replacement appliances will be provided only when Medically Necessary due to growth of child, progression of an Illness or Injury or no more than once every three years.
<b>Genetic Testing when Medically Necessary</b>	<p>Genetic testing when mandated by the Affordable Care Act or when Medically Necessary as long as such testing meets the following requirements:</p> <p>As further limited by Section 8.01, the test must not be an Experimental Procedure, investigational, or unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person. In some cases, testing may be accompanied with pre-test and post-test counseling.</p> <p>Genetic testing must also meet at least one of the following:</p> <ol style="list-style-type: none"> <li>1. the Covered Person has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes);</li> <li>2. conventional diagnosis procedures are inconclusive;</li> <li>3. the Covered Person has risk factors or a particular family history that indicates a genetic cause; or</li> <li>4. the Covered Person meets defined criteria that place him or her at high genetic risk for the condition.</li> </ol>
<b>Hearing Aids</b>	<p>Charges for medically necessary hearing aids. Hearing aids are subject to the \$1,500, per ear, every 5 years as shown in the Schedule of Benefits. Hearing aids are considered a non-essential health benefit, the participants coinsurance liability does not apply to the Calendar Year Out-of-Pocket Maximum.</p> <p>No coverage for Retirees.</p>

<b>Hemophilia and Other Congenital Bleeding Disorders</b>	Coverage for expenses Incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Coverage includes purchase of blood products and blood infusion equipment required for home treatment when the home treatment program is under the supervision of a state-approved hemophilia treatment center.
<b>HIV/AIDS</b>	HIV/ AIDS and Injuries or Illnesses as a result of HIV/AIDS will be Covered Expenses.
<b>Home Health Care</b>	<p>Services of a Home Health Care Agency for services furnished to a Covered Person in the home in accordance with a Home Health Care plan.</p> <p>The Home Health Care plan must be established and approved by the Physician and must certify that an inpatient Hospital confinement would otherwise be required.</p> <p>Covered Expenses include:</p> <ol style="list-style-type: none"> <li>1. Part time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.), if Medically Necessary;</li> <li>2. Part time or intermittent home health aide services performing services specifically ordered by a Physician;</li> <li>3. Occupational therapy, speech therapy, physical therapy and respiratory therapy provided by a Home Health Care Agency; and</li> <li>4. Medical supplies, medicines, and equipment prescribed by a Physician and provided by the Home Health Care Agency if such items would have been covered while Hospital confined.</li> </ol> <p>For determining the limit of benefits with respect to services set forth in items (1) and (2) above, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and 4 hours of home health aide services shall be considered as one home health care visit.</p> <p>In addition to the Limitations and Exclusions below, benefits will NOT be provided for any of the following:</p> <ol style="list-style-type: none"> <li>1. Services of a person who ordinarily resides in a Covered Person's home or is a member of the Covered Person's Family or spouse's Family;</li> <li>2. Custodial Care, consisting of services and supplies which are provided to an individual primarily to assist in the Activities of Daily Living;</li> <li>3. Any period during which the Covered Person is not under the continuing care of a Physician;</li> <li>4. Homemaker or housekeeping services except by home health aides as ordered in the Home Health Care treatment plan;</li> <li>5. Supportive environmental materials such as handrails, ramps, air conditioners and telephones;</li> <li>6. Services performed by volunteer workers;</li> <li>7. Social services and dietary assistance;</li> <li>8. Separate charges for records, reports or transportation;</li> </ol>



	<ol style="list-style-type: none"> <li>9. Expenses for the normal necessities of living, such as food, clothing, and household supplies;</li> <li>10. Services rendered or supplies furnished to other than the Covered Person;</li> <li>11. Any services or supplies not included in the Home Health Care treatment plan or not specifically set forth as a Covered Expense; and</li> <li>12. Services provided during any period of time in which the Covered Person is receiving benefits under this Plan's Hospice Care benefit.</li> </ol>
<b>Hospice Care</b>	<p>Hospice Care on either an Inpatient or Outpatient basis as an alternative to hospitalization for a Terminally Ill person.</p> <p>Covered services must be rendered, furnished and billed by a Hospice and included in a written Hospice treatment plan established and periodically reviewed by a Physician. The Hospice treatment plan must:</p> <ol style="list-style-type: none"> <li>1. Certify that the Covered Person is Terminally Ill and has less than a 6 month life expectancy;</li> <li>2. Certify that it is medically advisable for the Covered Person to live at home;</li> <li>3. Certify that Hospital confinement would be required in the absence of Hospice care; or</li> <li>4. Describe the services and supplies for the palliative care and Medically Necessary treatment to be provided to the Covered Person by the Hospice.</li> </ol> <p>Covered Expenses include:</p> <ol style="list-style-type: none"> <li>1. An assessment visit and initial testing;</li> <li>2. Room and board, services and supplies furnished by a Hospice while confined therein;</li> <li>3. Patient care provided by Home Health aides;</li> <li>4. Visits by speech therapists and psychotherapists;</li> <li>5. Intermittent care by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);</li> <li>6. Prescription Drugs and medicines for the Terminal Illness that are legally obtainable only upon a Physician's written prescription and insulin while receiving Hospice care on an Inpatient basis only;</li> <li>7. Medical supplies normally used for Hospital Inpatients, such as oxygen, catheters, needles, syringes, dressing, materials used in aseptic techniques, irrigation solutions, intravenous solutions and other medical supplies including splints, trusses, braces or crutches;</li> <li>8. Rental of Durable Medical Equipment;</li> <li>9. Family counseling of immediate Family members;</li> <li>10. Respite care;</li> <li>11. Professional medical, psychological, social and pastoral counseling services provided by salaried employees of the Hospice; and</li> </ol>

	<p>12. Supportive services to the bereaved immediate Family members for up to 3 months following the death of the Covered Person.</p> <p>In addition to the Limitations and Exclusions below, benefits will NOT be provided for any of the following:</p> <ol style="list-style-type: none"> <li>1. Homemaker or housekeeping services except by Home Health aides as ordered in the Hospice treatment plan;</li> <li>2. Supportive environmental materials such as handrails, ramps, air conditioners and telephones;</li> <li>3. Services performed by Family members or volunteer workers;</li> <li>4. "Meals on Wheels" or similar food services;</li> <li>5. Separate charges for records, reports or transportation;</li> <li>6. Expenses for the normal necessities of living, such as food, clothing and household supplies;</li> <li>7. Services rendered or supplies furnished to other than the Terminally Ill Covered Person except as listed above;</li> <li>8. Any services or supplies not included in the Hospice treatment plan or not specifically set forth as a Covered Expense;</li> <li>9. Legal and financial counseling services; and</li> <li>10. Services provided during any period of time in which the Covered Person is receiving benefits under this Plan's Home Health Care benefit.</li> </ol>
<p><b>Hospital Services:</b></p>	<p><b>Inpatient.</b> Hospital room and board, general nursing care, and regular daily services to the extent of the room and board allowance shown in the Schedule of Benefits.</p> <p><b>Note:</b> If a private room is used, the most frequent semi-private room rate will be a Covered Expense unless confinement in a private room is specifically requested by the Physician due to the nature of the Illness and/or Injury. An explanation must be submitted to the Claims Administrator.</p> <p>Intensive Care Unit or other special care unit such as coronary care, up to the amount specified in the Schedule of Benefits (but not for the concurrent use of any other Hospital room).</p> <p>Medically Necessary services and supplies furnished by the Hospital while confined as an Inpatient, including but not limited to the following:</p> <ol style="list-style-type: none"> <li>1. Prescription Drugs and medicines</li> <li>2. Use of operating rooms, delivery and treatment rooms</li> <li>3. Laboratory and pathology services</li> <li>4. Radiological services, computerized axial tomography (CAT, ultra sound, nuclear medicine and magnetic resonance imaging (MRI)</li> <li>5. Surgical dressings, surgical supplies, splints and casts</li> <li>6. Blood transfusions including charges for blood, Blood Plasma, and blood expanders</li> <li>7. Oxygen and other respiratory services</li> </ol>

	<ol style="list-style-type: none"> <li>8. Basal metabolism tests, or equivalent</li> <li>9. Electro diagnostic services including but not limited to electrocardiograms, electroencephalograms, electromyograms, Holter monitoring and scanning and distress testing</li> <li>10. Physical therapy, shock therapy, radiation therapy, inhalation therapy and occupational therapy</li> <li>11. General anesthesia and anesthesia supplies</li> <li>12. Subdermally implanted devices or appliances necessary for the improvement of physiological function</li> <li>13. General nursing care provided by a Registered Nurse, or Licensed Vocation Nurse authorized by a Physician</li> <li>14. Electric shock and insulin shock treatments</li> <li>15. X-rays, radium, and radioisotope treatments</li> <li>16. Hemodialysis and peritoneal dialysis treatment</li> </ol> <p>Coverage is not extended for a Hospital when the services could be rendered by an Other Facility Provider at a lesser expense.</p> <p><b>Outpatient.</b> Medically Necessary services and supplies furnished by a Hospital while being treated on an Outpatient basis such as:</p> <ol style="list-style-type: none"> <li>1. Allergy testing;</li> <li>2. Chemotherapy;</li> <li>3. Dialysis;</li> <li>4. Emergency Room Services;</li> <li>5. Laboratory tests and X-rays;</li> <li>6. Preadmission testing;</li> <li>7. Radiation therapy;</li> <li>8. Respiratory therapy; and</li> <li>9. Surgical services.</li> </ol>
<b>Hysterectomy</b>	Medical expenses for laparoscopy–assisted vaginal hysterectomy and vaginal hysterectomy when Medically Necessary. Includes a minimum Hospital stay of 24 hours for laparoscopic hysterectomy and 48 hours for vaginal hysterectomy. Minimum hours are not required if attending Physician, in consultation with Covered Person, determines a shorter period of Hospital stay is appropriate.
<b>Immunization</b>	Immunizations, vaccinations, booster shots and well child office visits.
<b>Ingestion or Consumption of controlled Drugs</b>	Emergency medical care and treatment for the accidental ingestion or consumption of a controlled drug for Covered Persons under age 15.
<b>Lyme Disease</b>	Treatment to include not less than 30 days of intravenous antibiotic therapy, 60 days of oral antibiotic therapy, or both, and cover further treatment if recommended.

<b>Lymphedema</b>	Coverage for equipment, supplies, complex decongestive therapy, and Outpatient self-management training and education for the treatment of lymphedema if lawfully prescribed by a Physician.
<b>Mammography</b>	Coverage for one mammogram- every other year for Covered Persons ages 40-50 and annually for Covered Persons over age 50 will be payable as shown in the Schedule of Benefits.
<b>Mastectomy or Related Procedure</b>	Expenses Incurred with respect to a mastectomy or lymph node dissection in connection with breast cancer. For a mastectomy, the Plan will cover a minimum 48-hour Hospital stay. For lymph node dissection, the Plan will cover a 24-hour Hospital stay.
<b>Maternity Expenses</b>	<p>Expenses Incurred by a Participant or Spouse as shown in the Schedule of Benefits, for:</p> <ol style="list-style-type: none"> <li>1. Pregnancy to include prenatal care, services provided by a Birthing Center, one amniocentesis test per pregnancy, and up to 2 ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary);</li> <li>2. Midwife services with licensed midwife; and</li> <li>3. Complications of pregnancy. For an uncomplicated vaginal delivery, this Plan will cover a 48-hour Hospital stay. For an uncomplicated cesarean delivery, the Plan will cover a 96-hour Hospital stay.</li> </ol> <p>If a decision is made to discharge a mother or newborn before the expiration of the minimum hours above, coverage is provided for timely post-delivery care by a Physician, midwife, Registered Nurse, or other appropriate licensed health care provider and may be provided at the mother's home, a health care provider's office, or a health care facility.</p> <p>All maternity services are subject to the maternity and obstetrical Precertification requirements in Article 6 of this Plan. Notwithstanding anything to the contrary, this Plan will cover a 48-hour Hospital stay for a vaginal delivery and a 96-hour Hospital stay for a cesarean delivery. Maternity expenses incurred during a Hospital stay for either a vaginal or cesarean delivery will not be subject to the Precertification requirements in Article 6 of this Plan. Preventive Care benefits as described in this Section are not subject to such Precertification requirements.</p> <p><b>NOTE:</b> No benefits will be covered for maternity services incurred by dependent children except as classified as Preventive Care or as required by the No Surprises Act Addendum.</p>
<b>Medical and Surgical Supplies</b>	Casts, splints, trusses, braces, crutches, surgical dressings and other Medically Necessary supplies.
<b>Mental Health Conditions</b>	Covered Expenses for the diagnosis and treatment of a Mental Health Conditions. Effective as of January 1, 2014 only the diagnosis and treatment of mental health assessments as required by the Affordable Care Act and the Mental Health Parity and Addiction Equity Act shall be covered.
<b>Newborn Expenses</b>	<p>A healthy newborn that is the Dependent of an Employee and who is discharged with the mother on the same date, shall not be subject to a separate Deductible and Copayment, for the following Covered Expenses:</p> <ol style="list-style-type: none"> <li>1. Hospital nursery expenses.</li> <li>2. Pediatric care.</li> <li>3. Circumcision.</li> <li>4. Cleft Lip and related conditions as described above.</li> </ol>

	<p>5. Congenital defects and birth abnormalities.</p> <p><b>Note:</b> Newborn coverage shall include coverage for Illness or Injury, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity. Covered Expenses included transportation costs of the newborn to and from the nearest Hospital or other Emergency Care Facility appropriately staffed and equipped to treat the newborn's condition. The transportation must be Medically Necessary to protect the health and safety of the newborn as certified by the attending Physician.</p>
<b>Nursing Services</b>	Nursing care by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) prescribed by a Physician.
<b>Obstetric or Gynecological Care</b>	A female Participant or Dependent may select a properly credentialed obstetrician, gynecologist, family physician, internist, or other qualified Physician for obstetric and/or gynecological care. Covered Expenses include one well-woman examination per year, care related to pregnancy, and diagnosis, treatment, and referral for any obstetric or gynecological disease or condition. Dependent children are not eligible for any pregnancy benefits or prenatal care except as classified as Preventive Care.
<b>Occupational Therapy</b>	Occupational therapy rendered by a licensed Occupational Therapist or Certified Occupational Therapist Assistant (C.O.T.A.). This care must be prescribed by a Physician.
<b>Oral Surgery</b>	Medical expense for oral surgery when necessitated as the direct result of an Injury or Illness to natural teeth or dental prosthesis (chewing related expenses not covered).
<b>Organ Transplant</b>	<p>Medically Necessary organ or tissue transplant procedures for cornea, artery or vein, bone marrow, heart, heart and lung, heart valve, kidney, implantable prosthetic lenses in connection with cataracts, joint replacement, liver, prosthetic by-pass or replacement vessels, lung, musculoskeletal transplants, parathyroid transplants and all related Covered Expenses when Incurred by a Covered Person who is the recipient of such transplant, provided such organ transplants are "human to human" and not Experimental Procedures. In addition, organ and tissue procurement consisting of removing, preserving, and transporting the donated organ, are Covered Expenses subject to the maximums shown in the Schedule of Benefits and the following:</p> <ol style="list-style-type: none"> <li>1. If the donor is covered under this Plan, eligible medical expenses Incurred by the donor are Covered Expenses under this Plan to the extent donor benefits are not provided under the organ recipients plan or any other source.*</li> <li>2. If the recipient is covered under this Plan, eligible medical expenses Incurred by the organ recipient are Covered Expenses under the Plan.</li> <li>3. If both the donor and recipient are covered under this Plan, eligible medical expenses Incurred by each person will be treated separately.*</li> <li>4. If the donor is not covered under this Plan, eligible medical expenses Incurred by the donor will be paid under this Plan to the extent donor benefits are not provided under any other plan.*</li> <li>5. The reasonable and customary cost of securing an organ from a cadaver or tissue bank, including the organ, will be considered a Covered Service.*</li> <li>6. In no event will benefits payable in excess of the Plan's applicable maximum benefit amount while the Covered Person is covered under this Plan.</li> </ol>

7. If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue.

**Preauthorization is Required.** It is the Participant's responsibility to obtain preauthorization for all transplant related services prior to evaluation. Failure to obtain preauthorization for transplant services will result in non-payment. The types of approved transplants and medical criteria for those transplants must be deemed Medically Necessary and appropriate for the medical condition for which the transplant is proposed.

**Second Opinion Policy.** Medical Case Management will be responsible to notify any potential candidate when a second opinion is required at any time during the determination of benefits period. If a Participant is denied a transplant procedure by the designated transplant facility, the Participant shall be referred by Medical Case Management to a second facility for evaluation. If the second facility determines, for any reason, that the Participant is an unacceptable candidate for the transplant procedure, no benefits will be provided for further transplant related services and supplies regardless of a third designated or non-designated transplant facility's acceptance of the Participant. A designated transplant facility is a facility which has entered into an agreement through a national organ transplant network to render approved transplant services, to which the Plan has access. The designated transplant facility will be determined by Medical Case Management and may or may not be located within a Participant's geographical area.

**Benefit Period.** The period of time from the date the Participant receives Precertification and has an initial evaluation for the transplant procedure until the earliest of the following: one year from the date the transplant procedure was actually performed; or the date coverage under this provision terminates.

**Limitations.** A Participant is eligible for coverage for up to two transplants per lifetime. Multiple organ transplants performed at the same time are considered to be one procedure.

**Donor charges may not exceed \$20,000 of the Applicable Plan Limit.**

**Organ Transplant Exclusions.** No coverage will be provided for:

1. Any organ or tissue transplant from a non-human donor or for the use of non-human organs for extracorporeal support and/or maintenance, unless the Plan determines these services are not Experimental Procedures.
2. Any artificial device for transplantation/implantation, including, but not limited to an artificial or mechanical heart, lung, liver, or pancreas, unless the Plan determines these services are not Experimental Procedures.
3. Any organ or tissue transplant procedure, which is not specifically listed as a Covered Expense in the Plan.
4. Any organ or tissue transplant considered an Experimental Procedure.
5. Complications resulting from any excluded procedure.

The Plan is not responsible for any Participant's decision to receive treatment, services or supplies from a transplant facility, nor does the Plan make warrants or representations regarding the qualifications of providers of treatment, services or supplies provided by a transplant network facility.

<b>Organ Transplant Travel and Lodging Expenses</b>	<p>When a covered transplant is performed outside the Covered Person's geographic area (locations outside a 100-mile radius from the Covered Person's home) the following travel and lodging expenses will be paid as follows:</p> <ol style="list-style-type: none"> <li>1. Transportation costs for Covered Person and one member of the Covered Person's family to accompany the Covered Person to and from the Hospital;</li> <li>2. Ground transportation cost for members of the Covered Person's family to visit the Covered Person while confined at the transplant Hospital;</li> <li>3. Ground transportation cost for the Covered Person, and for a family member who accompanies the Covered Person, to receive essential medical care following the covered transplant;</li> <li>4. Lodging (not including meals) at or near the transplant Hospital for a family member while Covered Person is confined at the transplant Hospital;</li> <li>5. Lodging (not including meals) at or near the transplant Hospital for the Covered Person and a family member while the Covered Person is receiving essential medical care following the covered transplant.</li> </ol> <p>In no event shall lodging and travel expenses exceed \$100 per day or \$5,000 per Calendar Year.</p>
<b>Ostomy Supplies</b>	Ostomy supplies are a Covered Expense under the Plan.
<b>Ovarian Cancer Screening</b>	Transvaginal ultrasound and rectovaginal pelvic examination are covered for female Participants and Dependents age 25 and older who are at risk of ovarian cancer.
<b>Oxygen</b>	Medically Necessary oxygen and rental of equipment for its administration.
<b>Pain Management</b>	Access to a pain management specialist and coverage for treatment of pain, as defined in the Glossary, as recommended by a Pain Management Specialist for Medically Necessary medications and procedures required to diagnose and develop a pain treatment plan.
<b>Pap Smear</b>	One gynecological examination and pap smear annually for each Covered Person age 21 and over will be payable as shown in the Schedule of Benefits.
<b>Physical Therapy</b>	Physical therapy rendered by a licensed physical therapist or Physical Therapist Assistant (P.T.A.) prescribed by a Physician.
<b>Physician's Services</b>	<p>Services performed in a Physician's office on the same day or following business day for the same or related diagnosis, whether a Physician is seen or not, will be payable as shown in the Schedule of Benefits.</p> <p>Effective December 1, 2020, all items and services that are otherwise covered by the Plan and furnished by the following Just Kids Pediatrics or Your Health and Wellness providers are covered at 100%:</p> <ol style="list-style-type: none"> <li>1. NW OKC (Pediatrics Only) 13913 N. May Ave, Oklahoma City, OK</li> <li>2. SW OKC (Pediatrics Only) 2921 SW 89th St, Oklahoma City, OK</li> <li>3. Moore (Adult &amp; Pediatrics) 400 N. Eastern, Moore, OK</li> </ol>

	<ol style="list-style-type: none"> <li>4. Mustang (Adult &amp; Pediatric) 160 E. SW 59th, Mustang, OK</li> <li>5. Midwest City (Pediatrics Only) 901 S. Air Depot Blvd, Midwest City, OK</li> <li>6. Edmond (Pediatrics Only) 257 S. Coltrane, Edmond, OK</li> <li>7. Bethany (Adult and Pediatric) 7530 NW 23rd Street, Bethany, OK</li> <li>8. Tulsa (Pediatrics Only) 3516 E. 61st South, Suite B, Tulsa,</li> </ol>
<b>Postpartum Services</b>	<p>Postpartum services including, Inpatient and Home Health Care visit or visits in accordance with Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or the “Standards for Obstetric-Gynecologic Services” prepared by the American College of Obstetricians and Gynecologists, including any changes to such Guidelines or Standard within 6 months of publication or any official amendment thereof.</p>
<b>Prescription Drugs</b>	<p>FDA approved Prescription Drugs and medicines for the treatment of an Illness or Injury, required by law to be prescribed in writing by a Physician and dispensed by a licensed pharmacist are covered by the Prescription Drug Benefit. Physician-dispensed Prescription Drugs are Covered Expenses.</p>
<b>Preventive Care</b>	<p>Preventive Care including, but not limited to office visit, lab tests, x-rays, routine testing, vaccinations or inoculations, well child care, pap smears, mammograms, colon exams (age 50 and over) and PSA testing will be payable as shown in the Schedule of Benefits and, unless otherwise indicated to provide a greater benefit under the Plan, according to the requirements of the Affordable Care Act. If a diagnosis is indicated after a preventive exam, the exam will still be payable under the routine care benefit; however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.</p> <p>The preventive care services listed in the Schedule of Benefits above may change as USPSTF, CDC, and HRSA guidelines are modified and will be implemented by the Plan in the quantities and at the times required by applicable law or regulatory guidance.</p> <p>Preventive Care includes Breastfeeding Support. Breastfeeding Support means comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period. Breastfeeding Support also means costs for renting breastfeeding equipment (up to one, double-pump manual or electric breast pump) in conjunction with each birth, subject to the limitations as provided in this paragraph. Except as otherwise stated herein, rental is limited to the duration of breastfeeding. Rental of Hospital Grade Breast Pumps (i.e., HCPC E0604 or as determined by the Plan Administrator) if it is Medically Necessary for a Covered Person to use a Hospital Grade Breast Pump rather than a double-pump manual or electric breast pump, in which case rental shall be provided at no cost-sharing to the Covered Person at any time during breastfeeding for the duration of thereof.</p> <p>Effective May 12, 2023 (see the COVID-19 Addendum for coverage prior to May 12, 2023), qualifying coronavirus preventive services will be covered as required by Section 3203 of the CARES Act. Qualifying coronavirus preventive services include:</p> <ul style="list-style-type: none"> <li>• An evidence-based item or service that has in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF); or</li> </ul>



	<ul style="list-style-type: none"> <li>An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved (regardless of whether the recommendation is for routine use) (including, consistent with the applicable ACIP recommendation, all COVID-19 vaccines within the scope of the Emergency Use Authorization or Biologics License Application (BLA) for the particular vaccine and their administration).</li> </ul> <p>Coverage for qualifying coronavirus preventive services will begin 15 days after the date on which the applicable recommendation by the USPSTF or ACIP is made.</p>
<b>Private Duty Nursing</b>	Private duty nursing services of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) prescribed by a Physician. Private duty nursing services must be Precertified.
<b>Prostate Cancer</b>	Annual medically recognized diagnostic examination for the detection of prostate cancer, subject to the limits set forth in the Schedule of Benefits, including: <ol style="list-style-type: none"> <li>A physical examination for the detection of prostate cancer; and</li> <li>A prostate-specific antigen test for each male enrolled in the Plan who is: <ol style="list-style-type: none"> <li>At least 50 years of age and asymptomatic; or</li> <li>At least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.</li> </ol> </li> </ol>
<b>Radiation Therapy and Chemotherapy</b>	X-ray, radium, radioactive isotope therapy, and chemotherapy.
<b>Reconstructive Surgery</b>	Mastectomy and reconstructive surgical services required as a result of a mastectomy. If a Covered Person receives benefits under this Plan in connection with a mastectomy and elects breast reconstruction the coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for: <ol style="list-style-type: none"> <li>Reconstruction of the breast on which a mastectomy has been performed;</li> <li>Surgery and reconstruction of the other breast to produce a symmetrical appearance;</li> <li>Prosthesis and treatment of physical complications including lymphedemas; and</li> <li>External breast prostheses and bras.</li> </ol> <p>Breast reconstruction and implantation or removal of breast prostheses is a Covered Expense only when performed solely and directly as a result of a mastectomy that is Medically Necessary.</p>
<b>Respiratory Therapy</b>	Medically Necessary respiratory therapy when prescribed by a Physician.
<b>Scalp Hair Prosthesis</b>	Purchase of one scalp hair prosthesis (wig) when necessitated by hair loss due to the medical condition known as alopecia areata, or as the result of hair loss due to radiation or chemotherapy for diagnosed cancer will be payable as shown in the Schedule of Benefits.
<b>Skilled Nursing Facility</b>	Confinement in a Skilled Nursing Facility, provided: <ol style="list-style-type: none"> <li>Such confinement is under the supervision of a Physician;</li> </ol>

	<ol style="list-style-type: none"> <li>2. The attending Physician certifies 24-hour nursing care is necessary for recuperation from the Illness or Injury which required Hospital confinement; and</li> <li>3. Such confinement is for necessary recuperative care of the same condition requiring the prior hospitalization.</li> </ol> <p>The total of all Medically Necessary services and supplies (including room and board) furnished by the facility cannot exceed the maximum shown in the Schedule of Benefits.</p>
<b>Speech, Occupational, Physical, and ABA Therapy Services</b>	<p>Medically Necessary services for occupational and physical therapy are a covered benefit. Effective August 1, 2022, Medically Necessary speech therapy is a covered benefit without regard to whether it is necessary as the result of an accident.</p> <p>Charges for Medically Necessary applied behavior analysis treatment of autism and autism spectrum disorder rendered under the supervision of a Physician which is necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.</p>
<b>Spinal Manipulation Treatment</b>	<p>The detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference which is the result of or related to distortion, misalignment, or subluxation of or in the vertebrae column.</p>
<b>Surgery</b>	<p>Surgical expense benefits are payable in the amount of the Covered Expenses Incurred by a Covered Person for surgical procedures performed by one or more Physicians but not exceeding:</p> <ol style="list-style-type: none"> <li>1. The maximum Applicable Plan Limit indicated for each surgical procedure performed, and</li> <li>2. The Maximum Allowable for all surgical procedures performed in any one series of operations. The Maximum Allowable amount for all surgical procedures performed in any one series of operations is set forth below.</li> </ol> <p>The Maximum Allowable amount for all surgical procedures performed in any one series of operation is as follows:</p> <ol style="list-style-type: none"> <li>1. When two or more procedures are performed during the course of a single operation through the same incision, or in the same natural body orifice, or the same operative field, the Maximum Allowable amount will be equal to the largest of the procedure amount for the respective procedures plus 50% of the allowable amount for the second procedure.</li> <li>2. When two or more surgical procedures are performed at the same operative session in separate operative fields and through separate incisions, the Maximum Allowable amount shall be the sum of the procedure amount allowable for each procedure.</li> <li>3. When a bilateral procedure is performed at the same operative session in separate operative fields, the Maximum Allowable amount shall be 150% of the procedure amount allowable for the unilateral procedure.</li> <li>4. If an incidental procedure is carried out at the same time as a more complex primary procedure, then the benefits will be payable for only the primary procedure. Separate benefits will not be payable for any incidental procedures performed at the same time.</li> <li>5. Benefits for assistant surgeon's fees will not exceed twenty percent (20%) of the Maximum Allowable within the Applicable Plan Limit amount for the surgeon's fees.</li> <li>6. Separate payment will not be made for preoperative and postoperative care.</li> </ol>

**ARTICLE 8 LIMITATIONS AND EXCLUSIONS ON COVERED EXPENSES**

**Section 8.01. Limitations and Exclusions.** The Plan shall not pay for any service, procedure or supply Incurred by the Covered Person, unless it is specifically listed as a Covered Expense under Article 7. By way of illustration, the Plan excludes the following specific limitations and exclusions:

<b>Abortion</b>	Services or supplies for Abortion, except where the mother’s life is endangered by the pregnancy, as well as complications of Abortion.
<b>Adoption Expenses</b>	Adoption or surrogate expenses, except as specified.
<b>Acupuncture or Acupressure</b>	Services or supplies for Acupuncture or Acupressure.
<b>Alternative Medicine</b>	Including but not limited to, hydrotherapy, aromatherapy, naturopathy and homeopathic and holistic treatment.
<b>Applicable Plan Limit</b>	Charges that exceed the Applicable Plan Limit as defined in the Glossary.
<b>Bariatric/Gastric/Lap Band Surgery</b>	Services or surgery related to bariatric or weight loss surgery.
<b>Biofeedback</b>	Biofeedback services and supplies.
<b>Blood Donor Expenses</b>	Blood or Blood Plasma or Blood Donor Expenses, except as specifically covered under Covered Expenses or as may be deemed Medically Necessary by the Plan Administrator.
<b>Breast Reduction Surgery</b>	Breast Reduction Surgery when Medically Necessary and not Cosmetic.
<b>Claims Forms</b>	Charges for completing claim forms or similar paper work.
<b>Complications of Non-Covered Expenses</b>	To the extent permitted by law, treatment, service or care required as a result of complications from a treatment or service not covered under the Plan as defined in Article 7, Covered Expenses.
<b>Cosmetic or Reconstructive Surgery</b>	<p>Cosmetic or Reconstructive Surgery, only if such surgery is to restore bodily function or correct deformity resulting from an Illness or Injury covered under this Plan.</p> <p>Services or supplies for cosmetic or reconstructive surgeries and related treatments, including but not limited to:</p> <ol style="list-style-type: none"> <li>1. Surgical removal or reformation of sagging skin on any part of the body;</li> <li>2. Enlargement, reduction or other changes in appearance of any part of the body, unless specifically covered under Covered Expenses;</li> <li>3. Hair transplant or removal of hair by electrolysis;</li> <li>4. Chemical face peels or skin abrasions;</li> <li>5. Silicone injections;</li> <li>6. Scar revision;</li> <li>7. Removal of tattoos or birthmarks; and</li> <li>8. Surgical treatments of scarring secondary to acne or chicken pox to include, but not limited to, dermabrasion, chemical peel, salabrasion, and collagen injections.</li> </ol>

	This exclusion shall not apply to Cosmetic or Reconstructive Surgery specifically as listed as a Covered Expense, or as deemed Medically Necessary in connection with an Illness or Injury.
<b>Counseling</b>	Marriage, family, job, industrial or sex counseling and therapy.
<b>Court Ordered Treatment or Hospitalization</b>	Court ordered treatment or hospitalization is excluded unless such treatment is prescribed by a Physician and is a Covered Expense of the Plan.
<b>Custodial Care</b>	Custodial Care provided in the home that only assists with the Activities of Daily Living.
<b>Dental</b>	Dental services, supplies or surgeries unless specifically listed as a Covered Expense. This does not exclude benefits under the dental benefits portion of this Plan.
<b>Dentures</b>	Charges in connection with the fitting or wearing of dentures.
<b>Drugs</b>	Any drugs covered under the Prescription Benefit Program will be paid under the Prescription Benefit Program and not as a Covered Expense under the Plan.
<b>Durable Medical Equipment</b>	Unless specifically listed as a Covered Expense, Durable Medical Equipment which is not primarily or customarily used to serve a medical purpose, including but not limited to disposable sheaths and supplies, exercise or hygienic equipment, correction appliances (except casts, splints and dressings), support appliances and supplies such as stockings, air conditioners, humidifiers, heating pads, hot water bottles, personal care items, wigs and cases, whirlpools, jacuzzies and comfort items even if prescribed by a Physician.
<b>Examinations</b>	Examinations for: <ol style="list-style-type: none"> <li>1. Employment, insurance, licensing or litigation purposes;</li> <li>2. Eye refractions;</li> <li>3. Care and treatment of the teeth, gums or alveolar process; or</li> <li>4. Sports or recreational activity.</li> </ol> Screening examinations, including x-ray examinations made without film.
<b>Excess Expenses</b>	Covered Expenses in excess of the maximum benefits set forth in the Schedule of Benefits or in excess of Applicable Plan Limit.
<b>Exercise Programs and Equipment</b>	All costs related to exercise programs and equipment such as, but not limited to, bicycles and treadmills.
<b>Experimental Procedures</b>	Experimental Procedures as defined in the Glossary.
<b>Eye Glasses</b>	Services or supplies for the purchase or fitting of eye glasses or lenses except as allowed following cataract surgery or under the vision benefits section of this Plan located in Article 11.
<b>Fertility and Infertility Treatment</b>	Charges for all forms of infertility treatment, including but not limited to artificial insemination, other artificial methods of conception, in vitro fertilization, in vivo fertilization, services for a surrogate mother, or treatment of sexual dysfunctions not related to organic disease.

<b>Felonious Acts</b>	Expenses resulting from Injuries or Illness caused by felonies or other illegal acts.
<b>Foreign Travel</b>	Immunizations required for foreign travel.
<b>Foreign Care and Supplies</b>	Any charges for services received or supplies purchased outside the United States, unless the Covered Person is a resident of the United States and charges are necessarily Incurred while traveling on business or for pleasure.
<b>Genetic Testing</b>	The following are not Covered Expenses as it relates to genetic testing: <ol style="list-style-type: none"> <li>1. population screening without a personal or family history, with the exception of preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies;</li> <li>2. genetic testing for information purposes alone (e.g., testing of minors for adult-onset conditions and self-referrals or home testing); or</li> <li>3. genetic testing that qualifies as an Experimental Procedure, is investigational, or for unproven purposes.</li> </ol>
<b>Governmental Benefits</b>	<ol style="list-style-type: none"> <li>1. Hospital services (including room and board), supplies or equipment obtained at government expense at any Veteran's Administration Hospital or any other Hospital owned or leased by the federal government. This exclusion applies only for charges for the treatment of a service-related Disability;</li> <li>2. Any fee, service or supply received from any governmental body or subdivision thereof and any public or private educational institution;</li> <li>3. Services or supplies for conditions caused by or arising out of an act of war, armed action, aggression or terrorism; or</li> <li>4. Care of an Illness or Injury Incurred while on active or reserve military duty.</li> </ol>
<b>Hearing Exam and repairs of hearing aids.</b>	Hearing examinations, prescribing or fitting hearing aids and/or the repair of hearing aids.
<b>Hypnotism</b>	Hypnotism, hypnotic anesthesia and Biofeedback.
<b>Illegal Services or Supplies</b>	Expenses for any illegal services rendered or supplies furnished.
<b>Late Submittal Claims</b>	Services or supplies for which a claim is submitted late. See the Claims Procedures in Article 12 for more information.
<b>Lipectomy</b>	Services and supplies for lipectomy. This includes any surgical or suction lipectomy procedure.
<b>Luxury Equipment</b>	Luxury medical equipment when standard equipment is appropriate for the Covered Person's condition (i.e., motorized wheelchairs or other vehicles, bionic, or computerized artificial limbs).
<b>Maintenance Care</b>	Charges for maintenance care (i.e., services and supplies intended primarily to maintain a level of physical or mental function).

<b>Maternity Services for Dependent Children</b>	Benefits are not provided for an infant born to a Dependent child unless and until the child is legally adopted and becomes an Eligible Dependent of the Employee.
<b>Music Therapy</b>	Music therapy, remedial reading, recreational therapy and other forms of special education.
<b>Nerve Stimulators and TENS Unit.</b>	Charges for nerve stimulators including TENS units.
<b>No Legal Obligation</b>	Services or supplies for which the Participant or Dependent is not legally obligated to pay or which no charge would be made in absence of the Plan.
<b>Non-Licensed Provider</b>	Services of supplies provided by a Provider, practitioner or institution who or which is not legally licensed to provide those services or supplies in the jurisdiction where such services or supplies were provided.
<b>Non-Prescription Drugs</b>	Drugs, medications and supplies, which do not require a Physician's prescription and are not otherwise specifically listed as a Covered Expense and not covered under the Prescription Drug Benefit Program.
<b>Non-Professional Care</b>	Medical or surgical care that is not performed according to generally accepted professional standards.
<b>Not Medically Necessary</b>	Services or supplies that are not Medically Necessary for the diagnosis or treatment of an Illness or Injury.
<b>Obesity</b>	Surgical procedures for the treatment of obesity or any complications arising therefrom, to include, but not to be limited to, Mason Shunt, banding gastroplasty, or intestinal bypass; medical weight reduction programs including nutrients, counseling services of dieticians and nutritionists except to the extent required by law.
<b>Palliative or Cosmetic Foot Care</b>	Palliative or cosmetic foot care including flat feet conditions, supportive devices for the foot (custom made or over the counter), the treatment of subluxation of the foot, care of corns (except when the diagnosis of diabetes is present), toenails (except cutting procedures of the nail matrix for ingrown nails or infected nails; or when the diagnosis of diabetes is present), fallen arches, weak feet, chronic foot strain and symptomatic complaints of the foot.
<b>Pastoral Care</b>	Person-centered care in which a person's religious and/or spiritual needs are addressed.
<b>Personal Comfort</b>	Services or supplies for personal comfort or convenience, (i.e. private room, television, telephone, guest trays, etc.).
<b>Physical Reconditioning</b>	Physical reconditioning programs to restore, improve, or maintain the physical fitness of a Covered Person including but not limited to, physical activity, exercise programs or regimes and the equipment to perform such activities.
<b>Physical Therapy Hospital Admissions</b>	Hospital admissions mainly for physical therapy.
<b>Prescription Drugs</b>	Any Prescription Drugs covered under the Prescription Benefit Program and not as a Covered Expense under the Plan.

<b>Prior to Effective Date</b>	Services or supplies rendered prior to the Effective Date of coverage.
<b>Professional Services</b>	Professional services billed by a Physician and nurse while an employee of a Hospital.
<b>Provider Agreements</b>	Amounts charged by a Provider that are waived by way of discounts or other agreements made between the Covered Person and the Provider.
<b>Radial Keratotomy, Refractive Keratoplasty or Lasik</b>	Radial keratotomy, refractive keratoplasty, Lasik and other procedures performed solely for the correction of vision.
<b>Related Provider</b>	Services or supplies provided by persons who ordinarily reside at the same household, or who are related by blood, marriage or legal adoption to the Covered Person.
<b>Reversal of Sterilization</b>	Procedures or treatments to reverse prior sterilization.
<b>Rest Home</b>	Services provided by a rest home, convalescent facility, or nursing home that only assists with Activities of Daily Living such as bathing, dressing, walking, eating, preparing special diets, or supervising the taking of medications.
<b>Self-administered Service</b>	Services administered by the Covered Person.
<b>Sex Change</b>	Any expenses, treatment or procedure related to sex change or designed to alter physical characteristics to those of the opposite sex, or any treatment, studies or expenses related to a transsexual operation sex transformation.
<b>Substance Use Disorder Treatment</b>	Substance Use Disorder treatment benefits are not covered under the Plan.
<b>Tobacco Cessation</b>	Any and all Tobacco Cessation products or programs except as required by the Affordable Care Act.
<b>Taxes</b>	Charges for federal, state and local taxes.
<b>Temporomandibular (TMJ) and Other Orthognathic Surgery</b>	Temporomandibular joint surgery, orthognathic surgery, or dental care or treatment, dental surgery or dental appliances, unless such charges are made necessary by an Injury effected through external means and such Injury occurred while the Covered Person's coverage under this Plan was in effect.
<b>Treatment, Therapy, Remedial Education or Training</b>	Treatment, therapy, remedial education or training which is intended primarily to overcome or compensate for any hearing or speech impairment (except as otherwise specifically covered elsewhere in this Plan).
<b>Vision</b>	Routine eye exams and vision therapy, eyeglasses, non-prescription sunglasses or contact lenses, unless specifically provided for elsewhere in the Comprehensive Major Medical Benefits Section. This does not limit the vision benefits provided in Article 11 of this Plan.

<b>Vitamins and Food Supplements</b>	Charges for vitamins or food supplements except as specifically provided elsewhere in this Plan.
<b>Vocational Testing, Evaluation and Counseling</b>	Vocational and educational services rendered primarily for training or education purposes.
<b>Warning Devices</b>	Warning devices, stethoscopes, blood pressure cuffs or other types of apparatus used for self-diagnosis or monitoring.
<b>Weekend Hospital Admissions</b>	Admissions to a Hospital on a Friday or Saturday at the convenience of a family member or his/her Physician, when there is no condition jeopardizing the Covered Person's life or causing serious impairment to the Covered Person's bodily function.
<b>Workers' Compensation or Similar Law</b>	Services or supplies for any Illness or Injury covered by the Plan for which benefits of any nature are recovered, recoverable or found to be recoverable under Workers' Compensation, any occupational disease law, or any other similar law.

**Section 8.02. Covered Person's Right to Choose.** The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a Covered Expense, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if the provider is Out-of-Network, the Covered Person still has the right and privilege to utilize such provider at the Plan's reduced Coinsurance level with the Covered Person being responsible for a larger percentage of the total medical expense.



## ARTICLE 9 PRESCRIPTION DRUG BENEFITS

**Section 9.01. Deductibles/Out-of-Pocket Maximums.** Prescription Drugs are subject to the Deductibles described in the Prescription Drug Schedule of Benefits located in Article 3. Any amount paid out-of-pocket for Prescription Drug benefits do not count toward major medical Out-of-Pocket Maximums.

**Section 9.02. Retail Prescription Program.** To receive Prescription Drug benefits under the Plan, a Covered Person can purchase Prescription Drugs, except those Prescription Drugs covered under the Specialty Drug Program, from an In-Network pharmacy in amounts up to a 30-day supply as further described in the Schedule of Benefits.

**Section 9.03. Mail Service Prescription Program.** A Covered Person can order long-term maintenance Prescription Drugs by mail order in amounts up to a 90-day supply, as further described in the Schedule of Benefits.

**Section 9.04. Covered Prescription Drugs.** Covered Prescription Drugs include, but are not necessarily limited to the following:

- A. Federal legend drugs.
- B. Compound Prescriptions with a minimum of one federal legend ingredient in a therapeutic amount; provided however, that Compound Prescription benefits that exceed \$300 per year require Preauthorization from the Prescription Claims Preauthorization Provider listed in the Plan Identifying Information Section. Failure to obtain such Preauthorization will result in nonpayment of benefits
- C. Erectile dysfunction/organic impotence Prescription Drugs.
- D. Diabetic supplies including: insulin, syringes, needles, test kits when patient has diagnosis of being an insulin-dependent diabetic and the Physician prescribes home monitoring, and Omnipod kits and pods. No other diabetic- or insulin-related devices or durable medical equipment are covered.
- E. Prenatal vitamins.
- F. Oral contraceptives, implant, patch and injectable contraceptive drugs, intrauterine devices and prescription barrier methods.
- G. Diet control pills to treat Morbid Obesity only.
- H. Retin A up to age 26.
- I. Folic acid.

**Section 9.05. Prescription Drugs Excluded from The Prescription Drug Program.**

- A. Anabolic steroids, unless Medically Necessary.
- B. Anorexiant (any drug used for the purpose of weight loss), except to treat Morbid Obesity.
- C. Biological serums (immunological vaccines)
- D. Charges for administration or injection of any drug.
- E. Cosmetic indications and anti-wrinkle agents (e.g. Botox, Renova)
- F. Dermatologicals, hair growth stimulants (e.g. Rogaine).
- G. Dental aids and mouthwashes. This does not limit benefits provided under the Dental Benefits section of this Plan.

- H. Prescription Drugs covered under Workers Compensation, Medicare or Medicaid or other state or federal programs.
- I. Prescription Drugs intended for use in a Physician's office or settings other than home use.
- J. Prescription Drugs labeled, "Caution-limited by federal law to investigational use," or Experimental Procedures, even though a charge is made to the individual.
- K. Fertility/infertility medications.
- L. Foreign claims for DEA approved drugs or foreign drugs not FDA approved.
- M. Fluoride products.
- N. Growth hormones.
- O. Hematopoietic agents.
- P. Immunization agents, biological sera, blood or Blood Plasma.
- Q. Injectibles, except insulin.
- R. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, Ambulatory Care Facility, Extended Care Facility, Skilled Nursing Facility, substance use disorder treatment facility, Other Facility Provider, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- S. Non-legend drugs other than those specifically listed above.
- T. Nutritional supplements and mineral supplements.
- U. Over-the-counter drugs are excluded except those specifically listed above.
- V. Prescription pain medication, unless: (1) authorized by a letter of Medical Necessity from prescribing Physician which documents the condition(s) requiring this medication; and (2) the medication is appropriately prescribed in accordance with FDA guidelines.
- W. Prescriptions filled by providers outside the pharmacy network.
- X. Prescription Drugs or refills of Prescriptions obtained more than one year after the original Prescription date or prior to 75% of the completion of the projected usage.
- Y. Prescription Drug expenses excluded under the group major medical provision of the Plan.
- Z. Smoking deterrent medications.
- AA. Therapeutic devices or appliances, including support garments, respiratory chambers (e.g. Aerochamber), ostomy supplies, and other non-medicinal substances.
- BB. Tretinoin topical (e.g. Retin-A) for individuals 26 years or older.
- CC. Vaccines.
- DD. Vitamins or minerals, singly or in combination. Exception: Legend prenatal vitamins are covered for pregnancy.
- EE. Substance Use Disorder medications.

Any Prescription Drug listed by brand name in this Section shall include its generic equivalent when available.

**ARTICLE 10 DENTAL BENEFITS**

**Section 10.01. General.**

**DELTA DENTAL:** Please refer to your Delta Dental Benefits Booklet or contact Delta Dental directly at 405-607-2100 or 1-800-522-0188 for questions regarding your Delta Dental coverage and benefits.

To the extent the provisions in this Plan document differ from those under the Delta Dental governing documents, the Delta Dental governing documents will control.

Under your dental benefits program, you may go to any properly licensed dentist. However, it is to your advantage to go to a Delta Dental participating dentist because, typically, your out-of-pocket expenses will be lower. Delta Dental of Oklahoma provides two dental networks instead of just one and the opportunity to maximize savings should you choose to receive treatment from a Delta Dental PPO dentist. Please note that the Delta Dental Premier network is still available for those employees who prefer greater access versus maximum savings.

**Finding A Delta Dental Participating Dentist**

To find a participating dentist, ask your dentist if he or she is a Delta Dental participating dentist; refer to Delta Dental’s National Dentist Directory on the Internet at [www.DeltaDentalOK.org](http://www.DeltaDentalOK.org); or call Delta Dental’s customer service department at 405-607-2100 or toll-free at 1-800-522-0188.

**The Advantage of Predetermination**

If you are having dental work done that will cost more than \$250, your dentist can request a predetermination of benefits by Delta Dental before starting treatment. The predetermination procedure is provided by Delta Dental to ensure that you know exactly whether the proposed treatment is covered under your program, how much the dental service will cost, and your share of the cost.

**Filing Your Claim**

The Delta Dental participating dentist will file your claim to Delta Dental of Oklahoma Claims Processing Center P.O. Box 548809 Oklahoma City, OK 73154-8809

**Section 10.02. Dental Schedule of Benefits.**

	<b>PPO &amp; Premier Network</b>	<b>Out-of-Network</b>
<b>Calendar Year Deductible</b>		
Class I – Per Person	None	None
Classes II, III & IV – Per Person	None	\$50
<b>Calendar Year Maximum</b>		
Classes I, II, & III – Per Person	\$2,000	\$1,500*
<i>*Note: Benefits for Class I services provided by out-of-network providers are limited to \$200 maximum per person per calendar year.</i>		
<b>Lifetime Maximum</b>		
Class IV Only – Orthodontic Per Child	\$3,000*	\$2,000**
<i>**Note: The lifetime maximum for Class IV is separate from the calendar year maximum(s) for Classes I, II &amp; III.</i>		

**Section 10.03. Covered Services and Plan Co-Payments.**

- A. **Class I Services.** PPO & Premier Networks 100%; Out-of-Network 100% up to \$200
  - 1. Oral evaluations

2. Routine prophylaxis, including cleaning and polishing
  3. Bite-wing and periapical x-rays once every 6 months
  4. Full-mouth x-rays once every 5 years
  5. Space maintainers to replace prematurely lost teeth of eligible dependent children (not for orthodontic purposes)
  6. Topical application of fluoride for eligible dependent children
- B. Class II Services.** PPO & Premier Networks 80%; Out-of-Network 70%
1. Minor emergency (palliative) treatment for relief of pain
  2. Topical application of sealants (for eligible dependent children only), limited to permanent first and second molars free of caries and restorations on the occlusal surface
  3. Amalgam and composite fillings
  4. Endodontics: includes pulpal therapy and root canal treatment
  5. Oral Surgery: procedures for extractions and other oral surgery, including pre and post-operative care. Note: Covered expenses for bony impactions are paid under the Plan's Medical Expense Benefits (applies to teeth nos. 16, 17, 1 and 32).
  6. Periodontics: procedures performed for the treatment of diseases of the gums and supporting structures of the teeth, including periodontal maintenance following active therapy (D4910)
  7. Stainless steel crowns (for eligible dependent children only) when the natural teeth cannot be restored with another filling material
  8. General anesthesia/IV sedation when administered in the dental office by a properly licensed dentist in conjunction with covered oral surgery, and nitrous oxide
- C. Class III Services.** PPO & Premier Networks 60%; Out-of-Network 50%
1. Major Restorative: provides porcelain or cast restorations (other than stainless steel) when teeth cannot be restored with another filling material
  2. Prosthodontic: procedures for construction of fixed bridges, partial dentures, and complete dentures
  3. Implants: procedures for implant placement, implant supported prosthetics, and maintenance and repair of implants and implant-supported prosthetics provided under this Plan
- D. Class IV Services.** PPO & Premier Networks 50%; Out-of-Network 50%
1. Orthodontic: The necessary treatment and procedures required for the correction of malposed teeth. Note: Benefits for orthodontic services are available only to eligible dependent children under the age of 19.

**Note:** Some covered services indicated above are subject to limitations such as age of patient, frequency of procedure, etc., or excluded in certain instances. If you have specific questions regarding your plan benefits, please contact Delta Dental of Oklahoma at the toll-free number included in this brochure.

**Note:** The Plan's percentage payment indicated next to each class of dental service will be based on the lesser of the dentist's submitted fee or the maximum allowable amount (prevailing fee, if out-of-networks), as calculated by Delta Dental.

**Note:** Eligible Dependent Children covered up to age 26. Exception: See Orthodontic limitation following.

**Note:** Orthodontic benefits are only available to eligible dependent children under the age of 19. Benefits are limited to payment of monthly or other periodic charges through completion of treatment, to the date treatment is terminated, to the date eligibility terminates, or to the date the maximum orthodontic benefit payment has been paid, whichever occurs first.

**Section 10.04. Dental Services Not Covered.**

- A. Benefits or services for injuries or conditions compensable under Workers' Compensation or Employers' Liability laws
- B. Benefits or services available from any federal or state government agency except those authorized by the Plan Sponsor, or from any municipality, county, or other political subdivision or community agency, or from any foundation or similar entity.
- C. Charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental coverage.
- D. Benefits for services if claim is received for payment more than 12 months after the date of service.
- E. Charges for treatment by other than a properly licensed dentist, except cleaning and scaling of teeth and topical application of fluoride may be performed by a properly licensed dental hygienist if treatment is rendered under the supervision and guidance of the dentist, in accordance with generally accepted dental standards.
- F. Charges for: (1) completion of forms or submission of supportive documentation required by DDOK for a benefit determination; (2) office visits, hospital calls, or house calls; (3) broken appointments; (4) hospitalization or additional fees charged for hospital treatment; (5) preventive control programs; (6) management fees; (7) bleaching of teeth.
- G. Benefits for services or appliances for which the date of service is prior to the patient's effective date of coverage under the Plan.
- H. Pre-medications.
- I. Experimental procedures.
- J. Charges for orthodontic treatment except as stipulated.
- K. Charges for replacement of lost or missing crowns or appliances, for replacement of stolen appliances, or for repair of an orthodontic appliance.
- L. Services with respect to diagnosis and treatment of disturbances of the temporomandibular joint (TMJ).
- M. Benefits or services to correct congenital or developmental malformations.
- N. Services for the purpose of improving appearance when form and function are satisfactory and there is insufficient pathological condition evident to warrant the treatment (cosmetic dentistry).
- O. Restorations for altering occlusion (bite), involving vertical dimensions, replacing tooth structure lost by attrition (grinding of teeth), erosion, abrasion (wear), or for periodontal, orthodontic, or other splinting.
- P. Charges for any dental service or supplies that are included as covered medical expenses under the plan of Major Medical or Comprehensive Medical Expense Benefits Plan must first be submitted to the medical carrier. This plan may benefit as a secondary carrier.

Q. All other benefits and services not specified in the Plan.

**ARTICLE 11 VISION BENEFITS**

<b>Vision Benefits (Participants and Dependents over age 18)</b>	<b>Maximum Calendar Year Benefits</b>
<b>Vision Testing Exams:</b> Covered one (1) exam per every twelve (12) months.	\$100.00
<b>Conventional Lenses: The Plan allows for either one (1) pair of conventional lenses or one (1) pair of contact lenses every 12 months, but not both.</b>	
Single Vision	\$185.00
Bi-Focal	\$200.00
Trifocal	\$200.00
Lenticular	\$200.00
<b>Contact Lenses</b>	\$180.00
<b>Eyeglass Frames</b>	\$200.00

<b>Vision Benefits (Dependents Age 18 and Under)</b>	<b>Maximum Calendar Year Benefits</b>
<b>Vision Testing Exams:</b> one (1) exam per every twelve (12) months.	100%
<b>Conventional Lenses: The Plan allows for either one (1) pair of conventional lenses or one (1) pair of contact lenses every 12 months, but not both.</b>	
Single Vision	100%
Bi-Focal	\$200.00
Trifocal	\$200.00
Lenticular	\$200.00
<b>Contact Lenses</b>	\$180.00
<b>Eyeglass Frames</b>	\$200.00

Note: Vision benefits are not subject to Plan Deductibles or Coinsurance. Vision Benefits are a straight reimbursement benefit payable up to the Calendar Year Maximum.

**ARTICLE 11A LIFE INSURANCE AND AD&D**

**Section 11A.01. Introduction.**

The Plan provides life insurance and accidental death and dismemberment (“AD&D”) benefits to Participants. The life insurance and AD&D benefits under the Plan are furnished pursuant to an insurance policy issued by an insurance company. **To the extent the provisions in this Plan document differ from those of the life insurance and AD&D policy or other governing documents, those such documents will control.**

A copy of the insurance policy document will be provided to you upon request and free of charge.

**Section 11A.02. Schedule of Benefits.** The amount of life and AD&D insurance of any Participant is based upon the following:

<b><u>Forms of Insurance:</u></b>	<b><u>Amount of Insurance:</u></b>
Life Insurance Benefit Active Participants	\$10,000* *The amount of insurance will be reduced by 35% at age 65, and 50% of the original amount of insurance at age 70. Benefits terminate at retirement.
Accelerated Life Insurance Benefit	An amount chosen by the Participant which shall not be: (1) less than \$5,000; or (2) more than 50% of the amount of life insurance.
Accidental Death and Dismemberment Benefit (AD&D) (Principal Sum) Active Participants	\$10,000*
Workplace Accidental Death Benefit	An additional amount equal to one times the standard AD&D amount up to a maximum of \$50,000.

\*The amount of insurance will be reduced by 35% at age 65, and 50% of the original amount of insurance at age 70. Benefits terminate at retirement.



## ARTICLE 12 CLAIMS AND APPEAL PROCEDURES

### Section 12.01. Claims Procedures.

The Plan Administrator has delegated to the Claims Administrator the initial authority to establish or construe the terms and conditions of the Plan and the discretion to interpret and determine benefits with respect to claims and appeals in accordance with the Plan's provisions. However, the Plan Administrator retains full and final discretion and authority to interpret the Plan and determine benefits. The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Plan.

All claim forms needed for filing for Benefits under the Plan can be obtained from the Plan Administrator. The instructions on the claim form should be followed carefully. Be sure all questions are answered fully and any required medical statements and bills are attached.

The completed claim form with bills is your proof of loss. You should make a copy for your records and the original should be sent to the Claims Administrator at the address shown on the claim form.

Satisfactory written proof of loss must be furnished to the Claims Administrator within ninety (90) days after the end of the Plan Year for which claim is made.

Failure to furnish proof of loss within the time fixed in the Plan will not invalidate or reduce any claim if it is shown that it was not reasonably possible to furnish such proof within such time and that such proof was furnished as soon as was reasonably possible.

Once a fully completed claim is submitted, you should generally hear from the Claims Administrator within ninety (90) days. In this ninety (90)-day period, the Claims Administrator will:

- A. Pay the claim;
- B. Request additional information;
- C. Turn down part, or all, of the claim; or
- D. There may be situations when additional time is needed for further handling. The Covered Person will be told why the extra time is needed.

The Claims Administrator shall have the full discretion to deny or grant a claim in whole or in part and shall determine whether to pay or deny the claim. If notice of the denial of a claim is not furnished in accordance with the above, the claim shall be deemed denied and you can exercise your right to appeal a denied claim.

Any payment made by the Plan in accordance with this section will fully discharge the Union's liability to the extent of such payment.

The Plan pays Benefits for care or services covered hereunder. Pending a determination of whether or not such care is covered, and to the extent such care or services have been provided, the Plan shall be entitled to recoup and recover the amount paid thereof from the Employee or the Provider of services in the event it is determined that such care or service is not covered hereunder. The Employee shall execute and deliver to the Plan Administrator all assignments and other documents necessary or useful to the plan for the purpose of enforcing its rights under this provision.

**Section 12.02. Release of Information.** The Plan may request, and anyone may give to the Plan Administrator, any information (including, but not limited to, copies of payroll and medical records) to verify eligibility for coverage under the Plan or about Illness or Injury for which Benefits are claimed.

### **Section 12.03. Payment of Benefits.**

Benefits under the Plan will be based upon the allowable charge (as determined by the Claims Administrator) for Covered Services. A PPO Provider will accept the allowable charge as payment in full and will make no additional charge to a Covered Person for Covered Services. However, if a Covered Person receives Covered Services from a Non-Network Provider (Non-PPO), he/she may be responsible for amounts, which exceed the allowable charge, in addition to the Deductible, Co-payment and/or Coinsurance amounts.

In some cases, a Provider who has a participating Provider agreement with the Claims Administrator may render Covered Services. These Providers have also agreed to charge Covered Persons no more than the allowable charge for Covered Services as specified in the Provider's participating Provider agreement. However, you may be responsible for amounts which exceed the allowable charge, in addition to any Deductibles, Co-payments and/or Coinsurance amounts, which apply to Out-of-Network (Non-PPO) services

Benefits are payable to the covered Employee (or to the custodial parent, the Provider, or the designated state agency in the case of a Qualified Medical Child Support Order or other court or administrative order) whose Injury or Illness or whose covered Dependent's Injury or Illness is the basis of claim under the Plan. However, the Claims Administrator is authorized, on behalf of the Plan, to make payments directly to Providers furnishing Covered Services for which Benefits are provided under the Plan.

Benefits payable for any loss other than that for which the Plan provides periodic payments will be paid upon receipt of proof of such loss. Subject to proof of loss, Benefits payable for each week during any period for which the Employer is liable, and any balance remaining unpaid upon the termination of the Employer's liability will be paid upon receipt of proof.

Whenever, in the Plan Administrator's opinion, a person entitled to receive any payment or a Benefit or installment thereof is under a legal disability or is incapacitated in any way so as to be unable to manage his financial affairs, the Plan Administrator may direct the Claims Administrator to make payments to such person, or legal representative, or to a relative or friend of such person, for such person's benefit; or the Plan Administrator may direct the Claims Administrator to apply the payment for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment of a Benefit or installment thereof in accordance with the provisions of this section shall be a complete discharge of any liability for the making of such payment under the provisions of the Plan.

If a Covered Person dies before all amounts payable to him/her have been paid, the Plan will pay such amounts to his/her personal representative, executor or administrator, provided that the Plan may, in its sole discretion, pay all or part of such amounts to the spouse of such Covered Person, if living, otherwise to his surviving children equally; or if there is no surviving child, to the Covered Person's parents, or to the survivor of them.

Subject to any written direction of the Covered Person in a request for coverage or otherwise, all or a portion of the Benefits, if any, provided by the Plan on account of Hospital, nursing, medical or surgical services may, at the Plan Administrator's option, and unless the Covered Person requests otherwise in writing not later than the time proof of loss is filed, be paid directly to the Hospital or person rendering such service; but it is not required that the service be rendered by a particular Hospital or person.

When part or all of a claim is denied, the Covered Person will be advised:

- A. Why it was denied.
- B. The specific reason(s) for denial of the claim.

- C. Any additional information the Covered Person needs to submit to have the claim processed (and why it is needed).

**Section 12.04. Claims Processes.** The following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only.

#### **Timing of Claim Decisions**

The Plan Administrator has delegated the authority to decide initial claims to the Claims Administrator. The Claims Administrator shall notify the claimant, in accordance with the provisions set forth below, of a benefit determination (whether adverse or not), in the case of Urgent Care Claims, Pre-service Non-urgent Claims, Concurrent Claims or Post Claims, within the following timeframes:

##### **A. Urgent Care Claims.**

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

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

The Claims Administrator shall notify the claimant of the benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim by the plan or health insurance coverage, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage.

In the case of such a failure, the Claims Administrator shall notify the claimant as soon as possible, but not later than 72 hours after receipt of the claim by the Plan, of the specific information necessary to complete the Claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

1. The plan's receipt of the specified information, or
2. The end of the period afforded the claimant to provide the specified additional information.

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

- B. **Pre-Service Non-urgent Care Claims.** A "pre-service claim" means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the

benefit in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see Article 6 for further information about pre-service Claims.

1. In the case of a pre-service Claim, the Claims Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the Claim by the Plan.
2. If the claimant has not provided all of the information needed to process the Claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the Claim.
3. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
4. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

If the Plan does not require the claimant to obtain approval of a specific medical service prior to getting treatment, then there is no Pre-service Claim. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

C. **Concurrent Claims.** If this Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments:

1. Plan Notice of Reduction or Termination. Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Claims Administrator shall notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
2. Request by Claimant Involving Non-Urgent Care. If the Claims Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).
3. Request by Claimant Involving Urgent Care. Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments for a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

D. **Post-Service Claims.** A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Non-Urgent Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

1. In the case of a post-service claim, the Claims Administrator shall notify the claimant of the Plan’s adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim.
2. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision.
3. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

E. **Calculating Time Periods.** The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. “Days” means calendar days.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
Insufficient information on the claim, or failure to follow the Plan’s procedures for filing a claim:	
• Notification to claimant, orally or in writing	24 hours
• Response by claimant, orally or in writing	48 hours
• Benefit determination, orally or in writing	48 hours
Ongoing courses of treatment (Concurrent Claims), notification of:	
• Reduction or termination before the end of treatment	24 hours
• Determination as to extending course of treatment	24 hours

In the case of a Pre-Service Non-urgent Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
• Notification of	15 days
• Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan’s procedures for filing a Claim	5 days
Ongoing courses of treatment (Concurrent Claims)	
• Reduction or termination before the end of the treatment	15 days
• Request to extend course of treatment	15 days

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days

Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days

**Section 12.05. Notice of an Adverse Benefit Determination.**

An adverse benefit determination eligible for claims and appeals processes includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment. An adverse benefit determination also includes any rescission of coverage as defined in the regulations restricting rescissions (26 CFR 54.9815-2712T(a)(2), 29 CFR 2590.715-2712(a)(2), and 45 CFR 147.128(a)(2)), whether or not the rescission has an adverse effect on any particular benefit at that time.

The Claims Administrator shall provide a claimant with a notice in a culturally and linguistically appropriate manner, either in writing or electronically, containing the following information:

- A. The specific reason or reasons for the adverse determination;
- B. Reference to the specific Plan provisions on which the determination was based;
- C. A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary;
- D. A description of the Plan’s review procedures and the time limits applicable to such procedures. This will include a statement of the claimant’s right to bring a civil action following an adverse benefit determination on review;
- E. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant’s claim for benefits;
- F. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- G. If the adverse benefit determination is based on a lack of medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- H. Any notice of adverse benefit determination or final internal adverse benefit determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

The Claims Administrator shall ensure that the reason or reasons for an adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan’s standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision.

The Claims Administrator shall provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

The Claims Administrator shall disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist enrollees with the internal claims and appeals and external review processes.

**Section 12.06. Internal Appeals of Adverse Benefit Determinations.** The Plan Administrator is responsible for internal appeals. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claims and adverse benefit determination. More specifically, the Plan provides:

- A. **Full and Fair Review of All Claims.** In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:
1. Claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;
  2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
  3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
  4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
  5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
  6. For the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
  7. That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits in possession of the Plan Administrator or the Claims Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances;

In the case of a claim involving urgent care, the Plan provides for an expedited review process pursuant to which:

1. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant;

2. All necessary information, including the plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method; and
3. The claimant may be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. Additionally, before the Plan can issue an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

- B. Internal Appeal Requirements for Internal Appeal.** The claimant must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the claimant's appeal must be addressed and mailed to the Plan Administrator at:

Plan Administrator  
Plumbers and Pipefitters Local Union 344 Health and Welfare Plan  
4337 SW 44th  
Oklahoma City, OK 73119

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

1. The name of the Employee/Claimant;
  2. The group name or identification number;
  3. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal;
  4. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
  5. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.
- C. Timing of Notification of Benefit Determination on Internal Appeal.** The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:
1. Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination on review on an expedited basis.
  2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
  3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.



4. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.
5. Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

**D. Manner and Content of Notification of Adverse Benefit Determination on Internal Appeal.** The Plan Administrator shall provide a claimant with notification in a culturally and linguistically appropriate manner, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan provisions on which the benefit determination is based;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures; This will include a statement of the claimant's right to bring a civil action following an adverse benefit determination on review;
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
7. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
8. Any notice of final internal adverse benefit determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
9. The reason or reasons for final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision;
10. A discussion of the decision for final internal adverse benefit determination;
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

**Section 12.07. Furnishing Documents in the Event of an Adverse Determination.** In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in “Manner and Content of Notification of Adverse Benefit Determination on Internal Appeal” as appropriate.

**Section 12.08. External Review.**

A. **Standard External Review.** This section sets forth procedures for standard external review for self-insured group health plans. Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. **Request for External Review.** A claimant may file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of a final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. **Preliminary Review.** Within five business days following the date of receipt of the external review request, the Claims Administrator shall complete a preliminary review of the request to determine whether:
  - a. The claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
  - b. The final adverse benefit determination does not relate to the claimant’s failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);
  - c. The claimant has exhausted the Plan’s internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations: and
  - d. The claimant has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the Claims Administrator must issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the plan must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization.** The Claims Administrator will assign an independent review organization (IRO) that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, this Plan will contract with at least three (3) IROs for assignments under the Plan and rotate claims assignment among

them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. A contract between the Plan and an IRO must provide the following:

- a. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan.
- b. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
- c. Within five business days after the date of assignment of the IRO, this plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.
- d. Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.
- e. The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
  - (i) The claimant's medical records;
  - (ii) The attending health care professional's recommendation;
  - (iii) Reports from appropriate health care professionals and other documents submitted by the plan, claimant, or the claimant's treating provider;

- (iv) The terms of the claimant’s plan to ensure that the IRO’s decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law:
  - (v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
  - (vi) Any applicable clinical review criteria developed and used by the plan, unless the criteria are inconsistent with the terms of the plan or with applicable law: and
  - (vii) The opinion of the IRO’s clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- f. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.
- g. The assigned IRO’s decision notice will contain:
- (i) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning , the treatment code and its corresponding meanings, and the reason for the previous denial);
  - (ii) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
  - (iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
  - (iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
  - (v) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the plan or to the claimant;
  - (vi) A statement that judicial review may be available to the claimant; and
  - (vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
- h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.
4. **Reversal of Plan’s Decision.** Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

## **B. Expedited Claim Review.**

1. **Request for Expedited External Review.** This Plan will allow a claimant to make a request for expedited external review. The Claims Administrator will decide if expedited review is available:
  - a. An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal: or
  - b. A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
2. **Preliminary Review.** Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. This Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.
3. **Referral to Independent Review Organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeal process.
4. **Notice of Final External Review Decision.** The IRO must provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the plan.

### **Section 12.09. General.**

During the pendency of any appeal, the Plan will provide continued coverage. The Plan shall comply with the requirements which generally provide that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

Note that, Claimant means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative. See 29 CFR 2590.715-2719(a)(2)(iii).

**Section 12.10. Appointment of Authorized Representative.**

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

In general, the Plan's claims and appeals procedures will comply with PPACA, including any deadlines related to adverse benefit determinations. Further, to the extent applicable, a claimant may file a written request for external review with respect to any adverse benefit determination in accordance with the PPACA and related regulations or other guidance. characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness.

### ARTICLE 13 COORDINATION OF BENEFITS

If a Covered Person is covered under more than one group plan, including this Plan and any other group medical benefits plan provided through or by the Employer, and one or more other plans, as defined below, benefits will be coordinated. The benefits payable under this Plan for any claim determination period, will be either its regular benefits or reduced benefits which, when added to the benefits of the other Plan, will equal 100% of the Allowable Expenses, also defined below.

**Section 13.01. Definitions.** The following terms have special meaning in the Coordination of Benefits Section:

- A. **Allowable Expenses.** Any Medically Necessary expense (other than Prescription Drug expenses) that is within the Applicable Plan Limit and is Incurred by a Covered Person which is covered at least in part under this Plan.
- B. **Claim Determination Period.** A Calendar Year or Plan Year or that portion of a Calendar Year or Plan Year during which the Covered Person for whom claim is made has been covered under the Plan.
- C. **Plan.** Any plan under which medical, dental, or vision benefits or services are provided by:
  - 1. Group, blanket or franchise insurance coverage;
  - 2. Any group Hospital service pre-payment, group medical service pre-payment, group practice or other group pre-payment coverage;
  - 3. Group coverage under labor-management trusted plans, union welfare plans, employer organization plans or employee benefits plans; or
  - 4. Coverage under governmental programs or coverage required or provided by any statute (including no fault auto insurance), except Medicare. (Refer to the Coordination of Benefits with Medicare provision for treatment of this coverage under this Plan.)

**Section 13.02. Effect of Health Maintenance Organization (HMO) Coverage.** This Plan will not consider as a Covered Expense any charge which is covered by an HMO which is the primary payer. This Plan will not consider any charge in excess of what an HMO provider has agreed to accept as a Covered Expense. The Plan will never consider a charge in excess of the Applicable Plan Limit.

**Section 13.03. Order of Benefit Determination.** When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the Allowable Expenses. No plan pays more than it would without the Coordination of Benefits provision. A plan without a Coordination of Benefits provision is always the primary plan. If all plans have such a provision:

- A. The plan covering the person directly, rather than as an Employee's Dependent, is primary and the others are secondary;
- B. For Dependent children of parents not separated or divorced, the plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second.

However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;

C. Dependent children of separated or divorced parents. When parents are separated or divorced, neither the male/female nor the birthday rule apply. Instead:

1. The plan of the parent with custody pays first;
2. The plan of the spouse of the parent with custody (the step-parent) pays next; and
3. The plan of the parent without custody pays last.

However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses and the insurer or other entity obliged to pay or provide the benefit of that parent's plan has actual knowledge of those terms, that plan pays first. If any benefits are actually paid or provided before that entity has actual knowledge, this "court decree" rule is not applicable during the remainder of the Calendar Year;

- D. Active/Inactive Employee. The plan covering a person as an Employee who is neither laid off nor retired (or as that person's Dependent) pays benefits first. The plan covering that person as a laid off or retired Employee (or as that person's Dependent) pays benefits second. If both plans do not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored;
- E. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- F. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
- G. If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.

The Coordination of Benefits provision may operate to reduce the total amount of benefits otherwise payable during any claim determination period with respect to a Covered Person under this Plan. When the benefits of this Plan are reduced, each benefit is reduced proportionately. The reduced amount is then charged against any applicable benefit limit of this Plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an allowance expense and a benefit paid.

**Section 13.04. Overpayment.** If the amount of the payment made by this Plan is more than it should have paid, the Plan has the right to recover the excess from one or more of the following:

- A. The person this Plan has paid or for whom it has paid;
- B. Insurance companies; and
- C. Other organizations.

In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Covered Person will be required to refund the overpayment. If payment is made on behalf of a Covered Person to a Hospital, Physician or other Provider of health care, and the payment is found to be an overpayment, the Plan will request a refund of the overpayment from the Provider. If the refund is not received from the Provider, or from the Covered Person, the amount of the overpayment will be



deducted from future benefits, if available. If future benefits are not available, the Covered Person will be required to refund the overpayment.

**Section 13.05. Payment to Other Carriers.** Whenever payments which should have been made under this Plan in accordance with the above provisions, have been made under any other plans, this Plan will have the right exercisable alone and in its sole discretion to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, this Plan will be fully discharged from liability.

**Section 13.06. Right to Receive and Release Necessary Information.** For the purpose of implementing the terms of this Plan, the Plan Administrator retains the right to request any medical information from any insurance company or other provider of service it deems necessary to properly process a claim. The Plan Administrator may, without consent of the Covered Person, release or obtain any information it deems necessary and as allowed under HIPAA. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

**Section 13.07. Coordination of Benefits with Medicare.**

- A. **Eligibility for Medicare.** A Participant may have coverage under the Plan and under Medicare. Medicare means benefits offered under Title XVII of the Social Security Act, and includes all of the benefits provided by Parts A and B of Medicare. When a Participant has coverage under both the Plan and Medicare, the Plan will pay primary benefits for:
1. An active employee who is age 65 and over;
  2. An active employee's Dependent spouse age 65 and over;
  3. An active employee or Dependent spouse under age 65 entitled to Medicare because of a Disability; or
  4. The first 30 months of treatment for End Stage Renal Disease received by any Participant.

If a Participant does not fall into one or more of the categories above, the Plan will pay benefits secondary to Medicare. When the Plan is secondary, the Participant must first submit the claim to Medicare. After Medicare makes payment, the Participant may submit the claim to the Plan for payment.

When a Participant files for Social Security benefits, the Participant automatically becomes eligible for Medicare Part A hospital coverage, which has no premium expense. A Participant may voluntarily enroll in Medicare Part B medical coverage and pay premiums.

**Note:** The definition of active employee for purposes of Medicare is different from the definition of Actively at Work or Employee for purposes of this Plan Document.

- B. **Election by Participant.** A Participant who is covered under Medicare and the Plan, and who falls into the categories above, may elect to waive coverage under the Plan. If coverage is waived under the Plan, the Plan will no longer provide coverage for that person. If a Participant waives coverage under the Plan, the Participant may later reapply for coverage under the Plan as a Late Enrollee. The rules governing Late Enrollees will apply. If a Participant elects Medicare as the primary coverage, the Participant will have no further coverage under this Plan.
- C. **HCFA Regulation.** This Article is based on regulations issued by the Health Care Financing Administration ("HCFA"), now known as Centers for Medicare and Medicaid Services ("CMS"), and may be amended or changed at any time. It is the intent of the Plan to abide by the Medicare

Secondary Payer Rules. The Plan will coordinate with Medicare to the fullest extent permitted by applicable law. If the Plan in any way conflicts with regulations issued by CMS, the Plan will pay benefits in accordance with CMS regulations.

## ARTICLE 14 SUBROGATION, THIRD-PARTY RECOVERY, AND REIMBURSEMENT

**Section 14.01. Benefits Subject to This Provision.** This provision shall apply to all benefits provided under any section of this Plan. This provision applies to all such benefits provided to (a) Covered Persons and Dependents, COBRA beneficiaries, family members, and any other person who may recover on behalf of a Covered Person or beneficiary including, but not limited to, the estate of a deceased Covered Person or beneficiary, (collectively referred to as "Covered Person"); and, (b) as well as to all other agents, attorneys, representatives, and persons acting for, on behalf of, in concert with, or at the direction of a Covered Person (sometimes referred to as "Covered Person's Representatives") with respect to such benefits.

**Section 14.02. When this Provision Applies.** A Covered Person may incur medical or other charges related to Injuries or Illnesses caused by the act or omission of Another Party including a physician or other Provider for acts or omissions including but not limited to malpractice; or Another Party may be liable or legally responsible for payment of charges Incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against Another Party for payment of the medical or other charges.

### Section 14.03. Defined Terms.

- A. **"Another Party"** shall mean any individual or entity, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Illnesses.

Another Party shall include the party or parties who caused the Injuries or Illness (first or third parties); the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; a medical malpractice or similar vaccination or a class action fund issue; and any other person, corporation or entity that is liable or legally responsible for payment in connection with the Injuries or Illness.

- B. **"Recovery"** shall mean any and all money, fund, property, compensation, as well as all rights thereto, or damages paid or available to the Covered Person by Another Party through insurance payments, settlement proceeds, first or third party payments or settlement proceeds, judgments, reimbursements or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness.
- C. **"Reimbursement" or "Reimburse"** shall mean repayment to the Plan for medical or other benefits paid or payable toward care and treatment of the Illness or Injury and for any other expenses Incurred by the Plan in connection with benefits paid or payable.
- D. **"Subrogation" or "Subrogate"** shall mean the Plan's right to pursue the Covered Person's claims against Another Party for medical or other charges paid by the Plan.

**Section 14.04. Conditions and Agreements.** Benefits are payable only upon the Covered Person's acceptance of, and compliance with, the terms and conditions of this Plan. The Covered Person agrees that acceptance of benefits is constructive notice of this Article. As a condition to receiving benefits under this Plan, a Covered Person and each Other Obligated Party agree(s):

- A. That the event a Covered Person under this Plan, and/or the Covered Person's Representatives receives any Recovery or other benefits arising out of any injury, accident, event, or incident for which the Covered Person has, may have, or asserts any claim or right to recovery under any theory of law or equity, tort, contract, statute, regulation, ordinance or otherwise against any other person, entity or source including, without limitation, any third party, insurer, insurance,

and/or insurance coverage (e.g., uninsured and underinsured motorist coverage, personal injury coverage, medical payments coverage, workers' compensation, etc.), then any payment or payments made by the Plan to Covered Person for such benefits shall be made on the condition and with the agreement and understanding that the Plan will be reimbursed by Covered Person and Covered Person's Representatives to the extent of, but not to exceed the Recovery amount or amounts received by Covered Person from such Another Party or source by way of any agreement, settlement judgment or otherwise;

- B. That the Plan shall be subrogated to all rights of Recovery the Covered Person has against Another Party potentially responsible for making any payment to Covered Person as a result of any injury, damage, loss or illness Covered Person sustains to the full extent of benefits provided or to be provided by the Plan to Covered Person or on Covered Person's behalf with respect to that illness, injury, damage or loss immediately upon the Plan's payment or provision of any benefits to Covered Person or on Covered Person's behalf. The Plan's recovery, subrogation and reimbursement rights provided herein exist even where a party allegedly at-fault or responsible for any loss, injury, damage or illness Covered Person sustains does not admit responsibility and regardless of the designation or characterization given to the funds Covered Person receives or agrees to be disbursed from that party or that party's representative;
- C. To notify the Plan Administrator if a Covered Person has a potential right to receive payment from someone else; to promptly execute and deliver to the Plan Administrator, if requested by the Plan Administrator or its representatives, a Subrogation and Reimbursement agreement; and, to supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests either to pay, or to not pay, medical or other benefits for the Injuries or Illness before the Subrogation and Reimbursement agreement has been signed; however, in either event, the Plan will still be entitled to Subrogation and Reimbursement according to the terms of this Section;
- D. To serve as a constructive trustee, and to hold in constructive trust for the benefit of the Plan any Recovery from Another Party, and agrees not to dissipate any such Recovery without prior written consent of the Plan, or to otherwise prejudice or impair the Plan's first rights to any such Recovery, regardless of how such Recovery may be characterized, designated or allocated. Covered Person agrees to hold, as trustee (or co-trustee) in trust for the benefit of the Plan all Recovery and funds Covered Person receives in payment of or as compensation for any injury, illness, damage and loss Covered Person sustained resulting from any such event, incident, accident, injury, illness and occurrence. Any such Recovery or funds received by, on behalf of, with the consent of, or at the direction of Covered Person, or to which Covered Person is entitled to receive or direct payment, or over which Covered Person (or a Covered Person's Representatives) has, or exercises, any control, are deemed and shall be considered and treated as assets of the Plan. Failure to hold Recovery and such funds in trust or to abide by these Plan terms will be deemed a breach of Covered Person's (or the Covered Person's Representative's) fiduciary duty to the Plan. The Plan has a right of subrogation or reimbursement before any Recovery and funds are paid to Covered Person from the responsible source and no attorneys' fees or costs may be subtracted from such amount. The Plan may, at its option and sole discretion, exercise either its subrogation and/or its repayment rights. The Plan is also entitled to any Recovery and funds Covered Person receives or is entitled to receive regardless of whether or not the payment represents full compensation to Covered Person. The Plan expressly disclaims all make whole and common fund rules and doctrines and/or any other rule or doctrine that would impair or interfere with the Plan's rights

herein. The Plan shall be entitled to an accounting from the Covered Person of all Recovery, funds and activities described herein;

- E. To restore to the Plan any such benefit paid or payable to, or on behalf of, the Covered Person when said benefits are paid or established by Another Party;
- F. To transfer title to the Plan for all benefits paid or payable as a result of said Illness or Injury. The Covered Person acknowledges that the Plan has a property interest in the Covered Person's Recovery, and that the Plan's Subrogation rights shall be considered a first priority claim to any Recovery, and shall be paid from any such Recovery before any other claims for the Covered Person as the result of the Illness or Injury, regardless of whether the Covered Person is made whole;
- G. That the Plan is granted a first right and priority to, as well as a first lien against, 100% of any Recovery to the extent of benefits paid or to be paid and expenses Incurred by the Plan in enforcing this provision; and such lien is an asset of the Plan. The Plan's first lien fully supersedes any right of first payment, or Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person is made whole or has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs;
- H. That the Covered Person also agrees to notify the Plan of Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation with respect to any matter for which Covered Person has obtained or will obtain any benefits from the Plan. Covered Person will be required to provide all information requested by the Plan or its representative regarding any such claim. Covered Person also agrees to keep the Plan informed as to all facts and communications that might affect the Plan's rights.
- I. To refrain from releasing Another Party that may be liable for or obligated to the Covered Person for the injury or condition without obtaining the Plan's written approval;
- J. To notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing a settlement agreement;
- K. Without limiting the preceding, the Plan shall be subrogated to any and all claims, causes, action or rights that the Covered Person has or that may arise against Another Party for which the Covered Person claims an entitlement to benefits under this Plan, regardless of how classified or characterized;
- L. If the Covered Person (or guardian or estate) decides to pursue Another Party, the Covered Person agrees to include the Plan's Subrogation claim in that action and if there is failure to do so, the Plan will be legally presumed to be included in such action or Recovery;
- M. In the event the Covered Person decides not to pursue Another Party, the Covered Person authorizes the Plan to pursue, sue, compromise or settle any such claim in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. Such cooperation shall include a duty to provide information and execute and deliver any acknowledgement or other legal instrument documenting the Plan's Subrogation rights. The Covered Person (or guardian or estate) agrees to take no prejudicial actions against the Subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its Subrogation claim. This includes attempts by the Covered Person, (or by his or her attorney or other agent) to have payments characterized as non-medical

in nature, or to direct or consent to have payments made to others (e.g., to or on behalf of relatives, attorneys, agents, representatives, or friends).

- N. The Plan will not pay, offset any Reimbursement, or in any way be responsible for any fees or costs associated with pursuing a claim unless the Plan agrees to do so in writing. The Plan's right of first Reimbursement will not be reduced for any reason including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;
- O. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of the Plan Document. The Plan Administrator may amend the Plan in its sole discretion at any time without notice. This right of Subrogation shall bind the Covered Person's guardian(s), estate, executor, personal representatives, and heirs.
- P. That the Plan Administrator may, in its sole discretion, require the Covered Person or his or her attorney to sign a subrogation/recovery agreement acknowledging and agreeing to the Plan's rights herein as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries.

**Section 14.05. When a Covered Person Retains an Attorney.**

If the Covered Person retains an attorney, the Plan Administrator may, in its sole discretion, require that the attorney sign a subrogation/recovery agreement acknowledging and agreeing to the Plan's rights herein as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will not pay the Covered Person's attorney's fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Covered Person's attorney's fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

An attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person's attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because neither the Covered Person nor his attorney is the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully Reimbursed.

In addition, the Plan may further require that (i) Covered Person utilizes the services of attorneys, representatives or agents who will execute a Reimbursement Agreement and who will not assert the make whole and common fund rule or doctrines, and (ii) Covered Person agrees to terminate any relationship with anyone who refuses to do so, or benefits will not be payable under the Plan in connection with that matter. The Plan is also entitled to receive and has priority to receive the first funds from payments received by Covered Person until the Plan has been repaid for all sums expended. Covered Person shall execute and deliver any instruments and documents reasonably requested by the Plan and shall do whatever is necessary to fully protect all the Plan's rights. Covered Person shall do nothing to prejudice the rights of the Plan to such reimbursement and subrogation, including, without limitation, any attempt by Covered Person or others to have payments characterized as non-medical in nature (e.g., for emotional distress, pain and suffering, embarrassment, mental anguish, loss of consortium, etc.) or to direct or consent to have payments made to others (e.g., to or on behalf of relatives, attorneys, agents, representatives or friends).

**Section 14.06. When the Covered Person is a Minor or is Deceased.** The provisions of this section apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or

personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the representative has access or control of the Recovery.

**Section 14.07. When a Covered Person Does Not Comply.**

- A. If (a) the subrogation agreement is not properly executed and returned as provided for in this provision; (b) information and assistance is not provided to the Plan Administrator upon request; or, (C) any other provision or obligation of this Article is not timely complied with, no benefits will be payable under the Plan with respect to costs Incurred in connection with such Illness or Injury.
- B. If a Covered Person fails to Reimburse the Plan for all benefits paid or to be paid, as a result of their Illness or Injury, out of any Recovery received as provided in this Plan, or otherwise fails to comply with any other provision or obligation of this Article, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money or property from the Covered Person; and, the Plan shall be entitled to offset and apply any future benefits that might otherwise be due, for the benefit of the Covered Person, the Covered Person's family members, or any other person who directly or indirectly acted or cooperated to interfere with, impair, or defeat the Plan's rights or interests against such reimbursements that should have been made to the Plan, as well as to suspend or terminate further coverage until such reimbursements are recovered by the Plan. This right of Reimbursement shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s).
- C. Additionally, Covered Person shall be fully responsible for the actions of Covered Person's Representatives, attorneys, agents, family members, and all persons acting for, on behalf of, in concert with, or at the direction of Covered Person regarding the Plan or Covered Person's obligations described herein. Covered Person shall be responsible to ensure that such persons cooperate and comply with Covered Person's obligations herein. If Covered Person or Covered Person's agents, attorneys or any other representative fails to fully cooperate with any subrogation, reimbursement, or repayment efforts, or directly or indirectly defeats, hinders, impedes, or interferes with any such efforts, Covered Person shall be responsible to account for and pay to the Plan all attorney's fees and costs incurred by or on behalf of the Plan in connection with such efforts.
- D. Additionally, the Plan may, in the discretion of its final decisionmaker, terminate Covered Person's participation in the Plan or the participation of any other person who directly or indirectly acted or cooperated to interfere with, impair, or defeat the Plan's rights or interest. In the event that any claim is made that any wording, term or provision set forth in this Subrogation and Right of Reimbursement portion of the Summary Plan Description is ambiguous or unclear, or if any questions arise concerning the meaning or intent of any of its terms, the Plan through its final decisionmaker, shall have the sole authority and discretion to construe, interpret and resolve all disputes regarding the interpretation of any such wording, term or provision.
- E. If it becomes necessary for the Plan to enforce this provision by initiating any action against Covered Person, then Covered Person agrees to pay the Plan's attorney's fees and costs associated with the action if the Plan prevails in that action. The Plan may offset any such fees and costs against covered Person's future medical expenses.
- F. The Plan's subrogation and reimbursement rights described herein are essential to ensure the equitable character of the Plan and its financial soundness, and to ensure that funds are recouped and made available for the benefit of all Covered Persons under the Plan collectively.





## ARTICLE 15 AMENDMENT, TERMINATION AND MERGER

**Section 15.01. Right to Amend, Merge or Consolidate.** The Board of Trustees reserves the right to merge or consolidate the Plan, and to make any amendment or restatement to the Plan from time-to-time, including those which are retroactive in effect. Such amendments may be applicable to any Covered Person.

**Section 15.02. Right to Terminate.** The Plan is intended to be permanent, but the Board of Trustees may at any time and without notice terminate the Plan in whole or in part.

**Section 15.03. Effect on Benefits.** If the Plan is amended or terminated, Covered Persons may not receive benefits described in the Plan after the effective date of such amendment or termination. Any such amendment or termination shall not affect a Covered Person's right to benefits for Claims Incurred prior to such amendment or termination. If the Plan is amended, Covered Persons may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA benefits. This may happen at any time. If this Plan is terminated, Covered Persons will not be entitled to any vested rights under the Plan.

## ARTICLE 16 PLAN ADMINISTRATION

**Section 16.01. Records; Tenure.** The Board of Trustees shall keep records of proceedings and claims. Each Trustee will serve until resignation or dismissal by the Board of Trustees pursuant to the terms of the Collective Bargaining Agreement and any vacancy or vacancies shall be filled in the same manner as the original appointments.

**Section 16.02. Powers of Plan Administrator.** Subject to the limitations of the Plan, the Board of Trustees will from time to time establish rules for the administration of the Plan and transaction of its business. The Board of Trustees will rely on the records of the Plan with respect to any and all factual matters dealing with the employment and eligibility of an Participant. The Board of Trustees will resolve any factual dispute, giving due weight to all evidence available to it. The Board of Trustees shall have such powers and duties as may be necessary to discharge its functions hereunder, including, but not limited to, the sole and absolute discretion to:

- A. Construe and interpret the Plan;
- B. Decide the questions of eligibility to participate in the Plan; and
- C. Determine the amount, manner and time of payment of any benefits to any Covered Person.

The Board of Trustees will have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and binding.

**Section 16.03. Outside Assistance.** The Board of Trustees may employ such counsel, accountants, Claims Administrators, consultants, actuaries and other person or persons as the Plan Administrator shall deem advisable. The Plan shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan.

**Section 16.04. Delegation of Powers.** In accordance with the provisions hereof, the Board of Trustees has been delegated certain administrative functions relating to the Plan with all powers necessary to enable the Board of Trustees properly to carry out such duties. The Board of Trustees as such shall have no power in any way to modify, alter, add to, or subtract from any provisions of the Plan other than expressly provided in this Article.

## **ARTICLE 17 STATEMENT OF ERISA RIGHTS**

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

### **Receive Information About Your Plan and Benefits**

You may examine, without charge, at the Plan's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

You may receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

### **Enforce Your Rights**

Your Claim is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of document relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Participant or Dependent can take to enforce his or her rights. For instance, if a request for Plan documents is made to the Plan Administrator and such requested information is not received within 30 days, you may file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$110 a day until such requested information is received by the requesting Participant or Dependent, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. Additionally, if a Claim for benefits is denied or ignored, in whole or in part, and if you have exhausted the Claims Procedures available to you under the Plan as described in Article 12, you may file suit in federal court.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The 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 the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

If it should happen that Plan Fiduciaries misuse the Plan's money, or if a Participant is discriminated against for asserting his or her rights, then such Participant may seek assistance from the U.S. Department of Labor, or file suit in federal court. The court will decide who should pay court costs and legal fees. If a Participant or Dependent is successful, the court may order the person sued to pay these costs and fees. If the Participant or Dependent loses, the court may order such Participant or Dependent to pay these costs and fees, for example, if the court finds the claim is frivolous.

### **Administrative Exhaustion Requirement**

All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought including a Claim for benefits or a claim for breach of Fiduciary duty.

**Limitation of Action:** Please Note: Any legal action for the recovery of any benefits or breach of Fiduciary duty must be commenced within two years after the Plan's Claim review procedures have been exhausted.

**Questions**

If you have any questions about this statement or your rights under ERISA or if you need assistance or information regarding your rights under HIPAA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

## ARTICLE 18 HIPAA PRIVACY AND SECURITY

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its implementing regulations restrict the Plan Sponsor’s ability to use and disclose Protected Health Information (“PHI”) and Electronic Protected Health Information (“Electronic PHI”). HIPAA also requires the Plan Sponsor to implement safeguards to protect the security of Protected Health Information. These restrictions and safeguards are outlined in the Plan Sponsor’s HIPAA Privacy and Security Policy. To request a copy of the Plan’s HIPAA Privacy and Security Policy, please contact the Benefits Department at (405) 682-4581.

### Section 18.01. Certain Definitions.

- A. **Protected Health Information (PHI)** means information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. PHI includes information of persons living or deceased.
- B. **Electronic Protected Health Information** means PHI that is transmitted by or maintained in electronic media.
- C. **Summary Health Information** means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan; and (2) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

**Section 18.02. HIPAA Privacy Practices.** The Plan Sponsor shall have access to PHI and Electronic PHI from the Plan only as permitted under this Plan or as otherwise required or permitted by HIPAA.

- A. **Permitted Disclosure of Enrollment/Disenrollment Information.** The Plan or a health insurance issuer may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan.
- B. **Permitted Uses and Disclosure of Summary Health Information.** The Plan or a health insurance issuer may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of (1) obtaining premium bids from the health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.
- C. **Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes.**

Unless otherwise permitted by law, the Plan or a health insurer may disclose PHI or Electronic PHI to the Plan Sponsor, provided that the Plan Sponsor uses or discloses such PHI and Electronic PHI only for Plan administration purposes. “Plan administration purposes” means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, Claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions.

Enrollment and disenrollment functions performed by the Plan Sponsor are performed on behalf of Plan participants and beneficiaries, and are not Plan administration functions. Enrollment and

disenrollment information held by the Plan Sponsor is held in its capacity as an employer and is not PHI.

Notwithstanding any provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

D. **Conditions of Disclosure for Plan Administration Purposes.** In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
2. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
4. Report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;
5. Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;
6. Make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR § 164.526;
7. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the Plan with HIPAA's privacy requirements;
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
10. Ensure that the adequate separation between Plan and Plan Sponsor, required by 45 CFR § 504(f)(2)(iii), is established.

E. **Adequate Separation Between Plan and Plan Sponsor.** The Plan Sponsor shall allow access to PHI to the following class of employees or other persons under the Plan Sponsor's control:

1. Human Resources
2. Accounting
3. Payroll

No other persons shall have access to PHI. The above-specified persons or class of persons shall only have access to and use of PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these persons or

class of persons do not comply with the provisions of this Section, the person shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's discipline procedures.

**Section 18.03. HIPAA Security Practices.** This Section relates to the disclosure of Electronic PHI to the Plan Sponsor for Plan administration functions. The Plan Sponsor agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than enrollment or disenrollment information, Summary Health Information and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR § 164.508, which are not subject to these restrictions) on behalf of the Plan, it will:

- A. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- B. Ensure that the adequate separation between the Plan and Plan Sponsor, required by 45 CFR § 504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- C. Ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- D. Report to the Plan any security incident of which it becomes aware, as follows: Plan Sponsor will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify or destroy Electronic PHI; in addition, the Plan Sponsor will report to the Plan as soon as feasible any successful unauthorized access, use, disclosure, modification, or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

## ARTICLE 19 GENERAL PROVISIONS

**Section 19.01. Verification.** The Plan Administrator shall be entitled to require reasonable information to verify any claim or the status of any person as a Covered Person. If the Covered Person does not supply the requested information within the applicable time limits or provide a release for such information, such Covered Person shall not be entitled to benefits under the Plan.

**Section 19.02. Limitation of Rights.** Nothing appearing in or done pursuant to the Plan shall be held or construed:

- A. To give any person any legal or equitable right against the Employer, any of their employees, or persons connected therewith, except as provided by law; or
- B. To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provided herein or as provided by law.

**Section 19.03. Governing Law.** This Plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the State of Oklahoma, except to the extent such laws are preempted by federal law.

**Section 19.04. Severability.** If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

**Section 19.05. Captions.** The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

**Section 19.06. Construction.** Any words herein used in the masculine shall also include the feminine and neutral where they would so apply. Words in the singular shall also include the plural and vice versa where they would so apply.

**Section 19.07. Entire Plan.** This document constitutes the entire Plan and there are no oral items or conditions to the contrary. Any change, modification or amendment to the Plan must be in writing.

**Section 19.08. Non-Guarantee of Employment.** Nothing contained in the Plan shall be construed as a contract of employment between the Employer and any Participant, or as a right of any Participant to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of the Participants, with or without cause.

**Section 19.09. Federal Tax Disclaimer.** To ensure compliance with requirements imposed by the IRS, we inform you that to the extent this communication (including any attachments) contains advice relating to a Federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of (i) avoiding any penalties that may be imposed on you or any other person or entity under the Internal Revenue Code or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein. If you are not the original addressee of this communication, you should seek advice from an independent advisor based on your particular circumstances.



## **ARTICLE 20 ST. ANTHONY SCORE PROGRAM**

Employees and Retirees of Plumbers and Pipefitters Local 344, who are covered by the Plan, are eligible to participate in the St. Anthony SCORE Program. Participants who are age 40 and over are eligible for one SCORE exam yearly. Participants who are less than age 40 are eligible for one SCORE exam every two years. Claims must be submitted to the Claims Administrator.

The following services are eligible under the St. Anthony SCORE Program:

93015 – Treadmill (exercise tolerance test);

93000 – EKG (Participants under age 40);

71010 – X-ray, chest, PA only, total unit;

80061 - Lipid Profile (cholesterol);

85025 - Complete Blood Count (CBC) w/differential (including, but not limited to, hemoglobin, white blood cell count, etc.);

81000 – Urinalysis, complete (checks for blood in urine);

80053 – Complete metabolic panel (includes, but not limited to, sodium, potassium, etc.); and

99396 – Complete physician exam.

**ARTICLE 21 SHORT-TERM DISABILITY**  
**SCHEDULE OF BENEFITS**

**CLASSIFICATION**

All Eligible Members

1. The Benefit Percentage is: 60% of Total Weekly Earnings.
2. The Maximum Weekly Benefit is: \$750.

**Elimination Period**

14 Days

**Maximum Benefit Period**

26 Weeks

**Effective Date**

The effective date for accepting contributions shall be July 1, 2011.

The effective date for eligibility to receive benefits shall be effective as of January 1, 2012.

**Funding Policy**

The Benefits payable under this Short-Term Disability provision shall be an unfunded promise to pay. Twenty cents per man hour worked shall be contributed to a separate account segregated from the general assets of those used to pay medical, pharmacy, dental and vision benefits. In the event, the segregated account used to pay disability benefits shall become insolvent, the disability feature shall terminate immediately and any unpaid disability benefits shall be void.

**DEFINITIONS**

In this section, the Plan defines some basic terms needed to understand this Short-Term Disability Plan. All male terms include the female term, unless stated otherwise. The definitions listed under this Article refers only to this Article.

For purposes of this Plan:

**Actively at Work** means that a Member performs all the regular duties of his job for a full work day scheduled by the Employer at a site where the Employer's business requires the Member to travel.

A Member is considered Actively at Work on any day that is not his regular scheduled work day (e.g. vacation or holiday), provided the Member was Actively at Work on his immediately preceding scheduled work day and the Member:

1. is not hospital confined; or
2. is not disabled due to an injury or sickness.

A Member is considered Actively at Work if he usually performs the regular duties of his job, provided the Member can perform all the regular duties of his job for a full work day and could do so at the Employer's normal place of business if required to do so, and the Member:

1. is not hospital confined; or
2. is not disabled due to an injury or sickness.

**Drug and Alcohol Illness** means an illness which results from the abuse of alcohol, drugs or derivatives.

**Eligibility Date** means the date or dates a Member in an Eligible Class becomes eligible for benefits under this Plan. Classes eligible for benefits are shown under Schedule of Benefits above.

**Gross Weekly Benefit** means the Member's Weekly Benefit before any reduction of Other Income Benefits as described in the Short-Term Disability Income Benefits section.

**Member** means a person who is employed by the Employer within the United States and paid regular earnings. If the Member is working on a temporary assignment outside of the United States for a period of 12 months or less, the Member will be deemed to be working within the United States.

**Elimination Period** means a period of continuous days of Total or Partial Disability for which no STD Benefit is payable. The Elimination Period is shown in the Schedule of Benefits section and begins on the first day of Total or Partial Disability.

**Employer** means Plumbers & Pipefitters Local Union 344 and includes any Subsidiary or Affiliated company named in the Application.

**Hospital or Institution** means a facility licensed to provide full-time medical care and treatment under the direction of a full-time staff of licensed physicians.

**Injury** means bodily impairment resulting directly from an accident and independently of all other causes. Any injury must occur and any disability must begin while the Member is insured under this Plan.

**Maximum Weekly Benefit** means the largest amount payable weekly to a Member under this Plan. The Maximum Weekly Benefit is shown in the Schedule of Benefits section.

**Mental Illness** means mental, nervous, psychological, emotional diseases, or behavioral disorders of any type.

**Net Weekly Benefit** means the amount payable after reducing the Member's Gross Weekly Benefit by any benefits the Member receives or is eligible to receive from sources listed as Other Income Benefits shown in the Short-Term Disability Income Benefits section.

**Partial Disability or Partially Disabled** means the Member, because of Injury or Sickness, is unable to perform all of the material and substantial duties of his own occupation on a full-time basis.

To qualify for benefits, the Member must satisfy the Elimination Period with the required number of days of Total Disability.

**Physician** means an individual who is operating within the scope of his license and is either:

1. licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
2. legally qualified as a medical practitioner and required to be recognized, under this Plan for insurance purposes, according to the insurance regulations of the governing jurisdiction.

The Physician cannot be the Member, his spouse or the parents, brothers, sisters or children of the Member or his spouse.

**Pregnancy** means childbirth, miscarriage, abortion or any disease resulting from or aggravated by the pregnancy.

**STD** means Short Term Disability.

**Total Disability** means the Member, because of Injury or Sickness other than Mental Illness, is unable to perform all of the material and substantial duties of his own occupation and is not engaged in any occupation for wage or profit.

The loss of a professional or occupational license or the inability to obtain or qualify for a license for any reason does not, in itself, constitute Total Disability.

To qualify for benefits, the Member must satisfy the Elimination Period with the required number of days of Total Disability.

**Total Weekly Earnings** means the Member's basic weekly earnings as reported by the Employer immediately prior to the first date Total Disability begins. Total Weekly Earnings includes deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account, but does not include income received due to commissions, bonuses, overtime pay or any other extra compensation.

If a Member is paid on an hourly basis, Total Weekly Earnings will be based on the Member's hourly rate of pay, but will not exceed 40 hours per week.

**Waiting Period** means the length of time immediately before a Member's Eligibility Date during which he must be employed in an Eligible Class. Any period of time prior to the Plan Effective Date the Member was Actively at Work for the Employer as a full time or part-time Member will count towards completion of the Waiting Period. The Waiting Period is shown in the Schedule of Benefits section.

## **BENEFIT PROVISIONS**

### **Short-Term Disability Income Benefit – Other Income Benefits**

Other Income Benefits are those benefits provided or available to a Member while a Short-Term Disability Benefit is payable. These Other Income Benefits, other than retirement benefits, must be provided as a result of the same Total Disability payable under this Plan. Other Income Benefits include:

Any disability income benefits the Member is eligible for under:

1. any other group insurance plan of the Employer;
2. any governmental retirement system as a result of the Member's job with his Employer.

Other Income Benefits will include any amount described above which would have been available to the Member had he applied for that benefit.

### **Estimated Other Income**

If, at the time of calculating any STD benefit payments, the benefit a Member is entitled to apply for and receive under any Other Income Benefits has not been awarded or denied or if they have been denied and are being appealed, the Plan will continue to pay any STD benefit until the Member begins receiving any type of Income Benefit which shall be used to offset his future STD Benefits.

### **Short Term Disability Income Benefits – Adjustment of Benefits**

#### **Adjustment of Benefits**

The Member must notify the Plan of the amount of Other Income Benefits when it is approved or adjusted (other than cost of living increases). The Plan will make an adjustment to the Net Weekly Benefit payment when the Plan receives written notice of the amount of the Other Income Benefit. Written Notice must be sent within 31 days after receipt of the Other Income Benefit award.

If after the Plan makes an adjustment to the Net Weekly Benefit the Member has been underpaid, the Plan will make a lump sum refund of the amount that has been underpaid to the Member.

If after the Plan makes an adjustment to the Net Weekly Benefit the Member has been overpaid, the Member must reimburse the Plan the amount of the overpayment within 31 days of the award. The Plan has the option to reduce or eliminate future STD benefit payments instead of requiring reimbursement in a lump sum.

### **Cost of Living Freeze**

After the first deduction for each of the Other Income Benefits, the Plan will not reduce the STD benefit payments due to cost of living increases a Member receives from any of the sources described as Other Income Benefits. This increase does not apply to any increase in earnings the Member receives from employment.

### **Termination of Short-Term Disability Benefits**

Total Disability Benefits will cease on the earliest of:

1. the date the Member is no longer Totally Disabled.
2. the date the Member dies.
3. the end of the Maximum Benefit Period.
4. the date the Member fails to provide adequate employment earnings information or proof of continuing Total Disability as requested.
5. the date the Plan determines the Member is able to perform all of the material and substantial duties of his own occupation, even if the Member chooses not to work.

### **Short Term Disability Income Benefits – Limitations**

#### **Successive Periods**

Successive periods of Total Disability after a Net Weekly Benefit was payable will be considered a single period if the Member, in the time between the successive periods, was Actively at Work for less than:

1. two consecutive weeks, if due to the same or related causes;
2. one day, if due to an entirely unrelated cause.

The Member will not have to complete a new Elimination Period. The STD benefit will continue to be calculated based on the Member's Total Weekly Earnings in effect at the time the initial period of Total Disability began. The STD benefit will be payable, in total, for no longer than the Maximum Benefit Period at the time of the initial period of Total or Partial Disability.

This successive periods provision will cease to apply on the earliest of the following dates:

1. the date the Member becomes eligible for benefits under any other group STD policy; or
2. the date this Plan is terminated.

#### **Limitations**

1. No STD benefit will be payable for any Total Disability during any of the following periods:
2. any period the Member is not under the regular and continuing care of a Physician providing appropriate treatment by means of examination and testing in accordance with the disabling condition.

3. any period the Member fails to submit to any medical examination requested by The Plan.
4. any period the Member engages in any occupation or employment for wage or profit other than Partial Disability employment for the Employer.
5. any period of Total Disability due to Drug and Alcohol Illness, unless the Member is actively supervised by a Physician or Rehabilitation Counselor and is receiving in-patient continuing treatment from a rehabilitation center or a designated institution approved by the Plan.
6. any member that is eligible to receive COBRA benefits, upon exhausting his hour bank, at the time he first becomes eligible to receive Short Term Disability Benefits.
7. any member that has previously received 26 weeks of benefits during a previous successive period of 12 consecutive months beginning on the date he files a request for disability.

#### **Short Term Disability Income Benefits – Exclusions**

No STD benefit will be payable for any Total Disability that is due to:

1. intentionally self-inflicted injury.
2. war, declared or undeclared, or any act of war.
3. active participation in a riot, rebellion or insurrection.
4. committing or attempting to commit an assault, felony or other criminal act.
5. injury or sickness sustained while doing any act or thing pertaining to any occupation for wage or profit.
6. injury that results in Workers Compensation benefits.
7. sickness that qualifies as a Mental Illness.
8. injury that results in Partial Disability.

#### **Claim Provisions**

If it is not possible to give proof within these time limits, it must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time proof is otherwise required unless the individual is legally incompetent.

Proof of Claim must consist of:

1. a description of the loss or disability;
2. the date the loss, disability or expense occurred; and
3. the cause of the loss, disability or expense.

Proof of Claim may include, but is not limited to, police accident reports, autopsy reports, laboratory results, toxicology results, hospital records, x-rays, narrative reports, or other diagnostic testing materials as required.

Proof of Claim for disability must include evidence demonstrating the disability including, but not limited to, hospital records, Physician records, Psychiatric records, x-rays, narrative reports, or other diagnostic testing materials as appropriate for the disabling condition.

Proof must be satisfactory to the Plan.

The Plan may require as part of the Proof authorizations to obtain medical and non-medical information.

Proof of the Member's continued disability and regular and continuous care by a Physician must be given to The Plan within 30 days of the request for proof.

#### **Plan Administrator's Authority**

The Plan Administrator has discretionary authority to make all final determinations regarding claims for benefits under the benefit plan insured by this Plan. This discretionary authority includes, but is not limited to, the determination of eligibility for benefits, based upon enrollment information provided by the Policyholder, and the amount of any benefits due, and to construe the terms of this Plan.

#### **Notice of Decision on Claim**

A written notice of decision on a claim will be sent within a reasonable time after the Plan receives the claim but not later than 45 days after receipt of the claim. If a decision cannot be made within 45 days after the Plan receives the claim, the Plan will request extensions of time as permitted under U.S. Department of Labor regulations. Any request for extension of time will specifically explain:

- the standards on which entitlement to benefits is based;
- the unresolved issues that prevent a decision on the claim; and
- the additional information needed to resolve those issues.

If a period of time is extended because the claimant failed to provide necessary information, the period for making the benefit determination is tolled from the date the Plan sends notice of the extension to the claimant until the date on which the claimant responds to the request for additional information. The claimant will have at least 45 days to provide the specified information.

#### **Review Procedure**

If all or any part of a claim is denied, the claimant may request in writing a review of the denial within 180 days after receiving notice of denial.

The claimant may submit written comments, documents, records or other information relating to the claim for benefits, and may request free of charge copies of all documents, records and other information relevant to the claimant's claim for benefits.

The Plan will review the claim on receipt of the written request for review, and will notify the claimant of the Plan's decision within a reasonable time but not later than 45 days after the request has been received. If an extension of time is required to process the claim, the Plan will notify the claimant in writing of the special circumstances requiring the extension and the date by which the Plan expects to make a determination on review. The extension cannot exceed a period of 45 days from the end of the initial review period.

If a period of time is extended because the claimant failed to provide necessary information, the period for making the decision on review is tolled from the date the Plan sends notice of the extension to the claimant until the date on which the claimant responds to the request for additional information.

#### **Time of Payment of Claims**

When the Plan receives satisfactory Proof of Claim, benefits payable under this Plan will be paid for any period for which the Plan is liable.

**Amendment or Termination of Benefit Provision**

A Member's rights to any disability benefits are determined on the date the Member's disability begins. The right is subject to the terms of this Plan in effect on the date disability begins and will not be affected by subsequent amendment or termination of this Plan.



## **ARTICLE 22 HEALTH REIMBURSEMENT ARRANGEMENT**

A Health Reimbursement Arrangement, or HRA, is an employer-funded health care reimbursement account that allows eligible individuals to obtain reimbursement of eligible medical expenses on a tax-free basis.

The Plan will establish and maintain an HRA account with respect to each eligible employee. These HRA accounts will be recordkeeping accounts for tracking contributions and available reimbursement amounts.

### **Eligibility to Participate**

You are generally eligible to participate in the HRA if:

1. you are a covered employee or dependent under the Plan; and
2. you do not engage in Competitive Employment.

### **Election to Suspend HRA Account**

A Covered Person may elect to suspend his or her HRA account for any future Plan Year by submitting a Suspension Election Form to the Plan Administrator before the beginning of that Plan Year. The Covered Person's suspension election will remain in effect for the entire Plan Year to which it applies, and the Covered Person may not modify or revoke the election during that Plan Year. The Covered Person will not receive reimbursements for any Eligible HRA Expenses incurred during the Plan Year to which the suspension election applies.

If a Participant suspends his or her HRA account for a Plan Year, the Employer will suspend contributions to the HRA account for that Plan Year. Eligible HRA Expenses incurred before the beginning of the suspended Plan Year will be reimbursed during the suspended Plan Year, subject to the reimbursement procedures outlined herein so long as no suspension election was in effect for the Plan Year in which such expenses were incurred.

### **Permanent Opt-Out**

In lieu of a temporary suspension of a Covered Person's HRA account as provided above, a Covered Person may elect to permanently opt out of and waive future reimbursements from his or her HRA account. A Covered Person who makes that election will not receive reimbursements for any Eligible HRA Expenses incurred after the opt-out election takes effect. Eligible HRA Expenses incurred before the opt-out election takes effect, however, may be reimbursed during the first Plan Year to which the opt-out election applies, subject to the reimbursement procedures contained herein, so long as no suspension election was in effect for the Plan Year in which such expenses were incurred.

If a Covered Person permanently opts out of this Plan, the Employer will also discontinue contributions to the Covered Person's HRA account.

The opportunity to make a permanent opt-out election shall be offered to each Covered Person at least annually.

### **Termination of Eligibility**

Your eligibility under the HRA will terminate on the earliest of the following to occur, subject to your right (if any) to continue coverage under the COBRA or Retiree self-payment provisions of this Plan:

1. the date your coverage as an employee terminates;
2. the date you become employed in Competitive Employment;

3. the date your coverage terminates because your employer has withdrawn from participation in the Plan; or
4. the date on which the HRA is terminated in accordance with the termination provisions of the Plan.

If your eligibility under the HRA terminates, no further contributions will be credited to your HRA account. If you do not again become eligible to participate in the HRA for at least one month in any calendar year, any balance remaining in your HRA account at the end of that calendar year will be forfeited and will not be reinstated. In order to participate again, you must satisfy the eligibility requirements for participation in the HRA.

### **HRA Contributions**

Contributions to your HRA account will consist of employer contributions made in accordance with a collective bargaining agreement or participating agreement with an employer requiring contributions to be submitted to the Plan. No contribution from employees or other persons is permitted.

If you are eligible to participate in the HRA, contributions will be credited (in dollars) to your HRA account each calendar year. Any unused amounts will be carried over into the next calendar year. The amount credited to your HRA account for a calendar year will be calculated as determined by the Board of Trustees.

The positive financial condition of the Fund has made it possible to establish the HRA and contribute to your HRA account. The amount of the total HRA contribution will be established each calendar year based on various data, including the Fund's financial condition and its reserve levels. The Trustees reserve the right to not make an HRA contribution in any given year or to amend or terminate the HRA.

### **Eligible HRA Expenses**

You may use your HRA account to obtain reimbursement for "Eligible HRA Expenses." Eligible HRA Expenses include "Covered Expenses," as defined under the Plan, to the extent not payable under the Plan or any other health plan or insurance, including amounts applied toward your deductibles and coinsurance percentages. In addition, Eligible HRA Expenses include:

1. premium for COBRA or Retiree self-payment coverage under the Plan for you and/or your eligible dependents;
2. amounts for Covered Expenses that are in excess of any lifetime maximums, per visit maximums, or calendar year maximums under the Plan;
3. amounts for Covered Expenses that are in excess of the "usual and customary" charges under the Plan; and
4. amounts for medical expenses that are deductible under Code § 213 and incurred by You or your dependents enrolled in coverage under the Plan.

Eligible HRA Expenses will not include any reductions in benefits because of your failure to obtain any required pre-admission certification or admission certification, as required by the Plan's utilization review program.

Eligible HRA Expenses may be incurred by you and/or your covered dependents who are enrolled in the Plan. To be reimbursable, Eligible HRA Expenses must be incurred on or after the date you and/or your dependents first become eligible to participate in the HRA and prior to the date your coverage under the HRA terminates.

Eligible HRA Expenses can only be reimbursed to the extent that you or your covered dependent who incurs the expense is not reimbursed for the expense through the Plan, nor is the expense reimbursable under any other insurance, or any other accident or health plan. If only a portion of an Eligible HRA Expense has been reimbursed elsewhere, the remaining portion of the expense can be reimbursed under the HRA account if it otherwise meets the requirements of an Eligible HRA Expense. To be reimbursable under the HRA, a claim for the Eligible HRA Expenses must first be either submitted for benefits under this Plan (and any other health plan under which you and/or your dependents are covered) or you may provide a paid receipt for any Eligible Expense. (Note: the requirements of this paragraph do not apply to reimbursement of premiums for COBRA or Retiree self-payment coverage.)

### **Submitting a Claim for Reimbursement**

In order to obtain reimbursement from your HRA account, you must submit a written claim to the Fund Office no later than March 31 following the end of the calendar year in which the Eligible HRA Expense was incurred. The claim must be submitted using an HRA Claim Form, which is available from the Fund Office. The claim form must be accompanied by an Explanation of Benefits (EOB) from this Plan and from any other plan covering the expense or a paid receipt. The EOB or the paid receipt should show the date the expenses were incurred, the total amount of the expenses, and the amount paid. Except for the final reimbursement claim for the calendar year, you must wait until the total reimbursement amount is at least \$25 before making a claim.

### **Reimbursement by the Plan**

Once a month the Fund Office will process claims on the 16th of the month for all claims submitted by the 6th day of the month, the Plan will reimburse you for the Eligible HRA Expenses if the claim is approved, or will notify you that your claim has been denied. This period may be extended for an additional 15 days for matters beyond the control of the Plan, including cases where a reimbursement claim is incomplete. The Plan will provide written notice of any extension, including the reasons for the extension, and will allow you 45 days in which to complete an incomplete reimbursement claim.

### **Carryover/Forfeiture of HRA Account Balances**

If any balance remains in your HRA account after all reimbursements have been made for a calendar year, the balance will be "carried over" to reimburse you for Eligible HRA Expenses incurred during a subsequent calendar year. However, if your participation in the HRA terminates and you do not again become eligible to participate in the HRA for at least one month in any calendar year, any balance remaining in your HRA account at the end of that calendar year will be forfeited and will not be carried over.

As mentioned above, your eligibility under the HRA will terminate on the date you become employed in Competitive Employment. In addition, any balance in your HRA on the date you become employed in Competitive Employment will be forfeited.

### **Reimbursement after Termination**

When your participation under the HRA terminates for any reason, you may receive reimbursements from any balance remaining in your HRA account for Eligible HRA Expenses incurred prior to termination. You must claim reimbursement for such Eligible HRA Expenses as described, above, under "Submitting a Claim for Reimbursement."

### **Tax Consequences**

The Plan makes no guarantee that any amounts paid under your HRA account will be excludable from your gross income for federal, state, or local income tax purposes. You must determine whether the HRA payments are excludable, and notify the Plan if you have any reason to believe that a payment is not

excludable. If you receive reimbursement under the HRA on a tax-free basis, and the payment does not qualify for tax-free treatment under the Internal Revenue Code of 1986, as amended, you will be required to indemnify and reimburse the Plan for any liability it incurs for failure to withhold federal income taxes, Social Security taxes, or other taxes.

#### **Coordination of Benefits**

Reimbursements under the HRA are solely for Eligible HRA Expenses not previously reimbursed or reimbursable elsewhere. If an Eligible HRA Expense is payable or reimbursable from another source, that other source must pay or reimburse before the HRA.

#### **Amendment and Termination**

The HRA has been established with the intent of being maintained for an indefinite period. However, the Board of Trustees reserves the right to amend or terminate all or any part of the HRA and the rules pertaining to its use at any time for any reason. You do not have a vested or non-forfeitable right to your HRA account or the contributions credited to it.

NOTE: Your receipt of this Notice is not a certification that you are eligible to receive any benefits under the Plan. You must satisfy the Plan's eligibility requirements to receive benefits. If you have any questions, please contact the Fund Office, 405-682-4581, or by mail at Plumbers and Pipefitters Local 344 Health and Welfare Fund, 4337 S.W. 44th Street, Oklahoma City, Oklahoma 73119.

#### **NOTICE**

This Plan will not be deemed to constitute a contract of employment or give any Employee of an Employer the right to remain in the service of the Employer or to interfere with the right of the Employer to discharge any Employee. These issues are covered by your Collective Bargaining and/or Participation Agreement.

You MUST satisfy all eligibility provisions in order to be eligible for the benefits of this Plan. Possession of the Booklet does not automatically entitle you to Plan benefits.

The Trustees have full and exclusive authority in their sole discretion to determine all questions of coverage and eligibility, methods of providing or arranging for benefits and other related matters. The Trustees also have full power to construe the provisions of the Agreement and Declaration of Trust for the Plan and the Amended and Restated Rules and Regulations of the Plan. Any such determination and any such construction adopted by the Trustees in good faith shall be binding on all entities and beneficiaries of this Plan.

## GLOSSARY

The following terms, as used in the Plan, shall have the meaning specified in this Glossary, unless a different meaning is clearly required by the context in which it is used:

**Actively at Work** shall mean performing the Employee's job at the location where the Employee generally reports to work. If such Employee is on vacation, Approved Leave of Absence, Approved Disability Leave, or is off due to a holiday or other reason approved by the Employer, the Employee will be deemed Actively at Work if the Employee was Actively at Work on the day immediately prior to the vacation, Approved Leave of Absence, day off or holiday.

**Active Employee** shall mean an Employee who is considered Actively at Work.

**Activities of Daily Living** shall refer to the following, with or without assistance:

1. Bathing, which is the cleansing of the body in either a tub or shower, or by sponge bath;
2. Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
3. Toileting, which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene;
4. Transferring, which is to move in and out of a bed, chair, wheelchair, tub or shower;
5. Mobility, which is to move from one place to another, with or without the assistance of equipment;
6. Eating, which is getting nourishment into the body by any means other than intravenous; and
7. Continence, which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene.

**Ambulatory Care Facility** shall mean a facility that provides Outpatient Care.

**Ambulatory Surgical Facility** shall mean an ambulatory surgical center, freestanding surgical center, or outpatient surgical center, which is not a part of a Hospital and which:

1. Has an organized medical staff of Physicians;
2. Has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
3. Has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility;
4. Is licensed by the jurisdiction in which it is located; and
5. Does not provide for overnight accommodations.

**Appeal** shall mean a request for review of a denial of benefits under the Plan and made in accordance with Article 12.

**Applicable Plan Limit** means the fees for services and supplies payable by the Plan, subject to any cost-sharing and other provisions of the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within the parameters listed below. The Plan Administrator has final authority to determine whether a fee is within the Applicable Plan Limit.

1. In-Network Services and Supplies. The Applicable Plan Limit with respect to In-Network services and supplies will be the allowed amount as provided by the Network agreement or any direct contract between the Plan and a provider or facility.
2. Out-of-Network Services and Supplies. The Applicable Plan Limit with respect to Out-of-Network services and supplies is determined in accordance with this paragraph.

With respect to hospitalization, emergency room, and ambulatory service charges, the Out-of-Network Applicable Plan Limit is 100% of the base Medicare reimbursement rate for the same or similar service or supplies. The Applicable Plan Limit with respect to all other Out-of-Network services and supplies is 50% of the base Medicare reimbursement rate for the same or similar service or supplies.

The Plan Administrator may, on a uniform and nondiscriminatory basis, (1) exclude from the Applicable Plan Limit any Medicare adjustment(s) which is/are based on information on the Claim, (2) utilize the same claims processing rules and/or edits that it utilizes in processing In-Network Claims or as consistent with the Medicare claim rules, and (3) not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limit to, disproportionate share and graduate medical education payments.

If a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the Claim, the Plan Administrator may apply different methodology to determine the Out-of-Network Applicable Plan Limit.

Notwithstanding the foregoing, the Out-of-Network Applicable Plan Limit will not be greater than the actual billed charge. The Out-of-Network Applicable Plan Limit does not equate to the billed charge, and Covered Persons receiving services from an Out-of-Network provider or facility will be responsible for the difference between the amount paid by the Plan and the billed charge, except as provided by the No Surprise Act Addendum. All Out-of-Network reimbursements are subject to the No Surprise Act Addendum, as applicable.

3. Pharmaceuticals. Pharmacy charge reimbursement is determined by applying the benefit payment provisions pursuant to the Plan's Prescription Drug Program vendor, which is subject to change from time to time. Please contact the Plan Administrator for more information.
4. Bundling/Unbundling/Upcoding/Error. The Claim may be reviewed to determine whether the Claim contains any of the following errors: bundling, unbundling, upcoding, and/or errors. If it is determined that the claim contains any of the aforementioned errors, the submitted Claim may be reduced based on discovered errors.

The aforementioned parameters do not increase nor alleviate the Plan Administrator's fiduciary duty to pay more or less than the amount it deems to be within the Applicable Plan Limit in its sole discretion and in accordance with ERISA. The Plan Administrator will take into consideration the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

**Approved Disability Leave** shall mean an approved leave for purposes of Disability. For purposes of this Section, the term "Disability" shall mean that the Employee is not able to perform the duties of the Employee's regular occupation with the Employer, as determined in the sole discretion of the Plan Administrator. An Approved Disability Leave shall terminate upon the Employee becoming eligible for Medicare.

**Approved Leave of Absence** shall mean a leave of absence approved by the Employer for a period not to exceed 6 consecutive months, with the stated intention of returning to full time employment with the Employer. For purposes of this document, the term Approved Leave of Absence shall not refer to leave under the Family and Medical Leave Act.

**Attained Age** shall mean the age in years of a Covered Person as of the last anniversary of his date of birth.

**Benefit Year** shall mean January 1 to December 31 of each year.

**Birth Center** shall mean a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24 hour nursing care provided by registered nurses or certified nurse midwives.

**Bone Mass Measurement** shall mean a scientifically proven radiologic, radioisotopic, or other procedure performed to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

**Calendar Year** shall mean January 1 to December 31 of each year.

**Calendar Year Deductible** shall mean Covered Expenses Incurred within the Calendar Year before the Plan will pay at the Benefit Percentage payable.

1. **Individual.** The Individual Deductible is specified in the Schedule of Benefits.
2. **Family.** The Family Deductible is specified in the Schedule of Benefits.

The Family Deductible for the Plan can be satisfied by combining Covered Expenses from each covered Family Member. However, each Covered Person cannot contribute more than one Individual Deductible amount to the Family Deductible.

**Calendar Year Maximum or Calendar Year Maximum Benefit** shall mean the maximum amount which will be paid to or on behalf of a Covered Person for Incurred Charges in any Benefit Year.

**Chiropractic Care** means all services related to a chiropractic visit and also means Spinal Manipulation Treatment.

**Claims Administrator** shall mean the person or persons appointed by the Board of Trustees to determine benefit eligibility and to adjudicate Claims under the Plan.

**COBRA** shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**COBRA Continuation Coverage or Continuation Coverage** shall mean the continuation of health care benefits for Participants and Dependents on the occurrence of a Qualifying Event as defined by COBRA, and as further set forth in the Continuation of Coverage Article.

**Code** shall mean the Internal Revenue Code of 1986, as amended, and its implementing regulations.

**Competitive Employment** shall mean performing work within the building trades industry with an employer who is not a signatory to the terms of a collective bargaining agreement with the Union or is not a Contributing Employer.

**Continuation Coverage** means COBRA or other applicable continuation of coverage laws as the context requires.

**Continuation Coverage Payments** shall mean the payments required for COBRA Continuation Coverage.

**Contributing Employer** shall mean any Employer who:

1. has a collective bargaining or other written agreement with the Union or the Trustees requiring periodic contributions to be made to the Plan;
2. signs a copy of the Trust Agreement or a Participation Agreement; or
3. is accepted for participation in the Fund by the Trustees or was a party to the Trust Agreement executed June 1, 1977.

The term Contributing Employer also includes the Union and the Fund provided either or both:

1. become obligated pursuant to a Participation Agreement with the Trustees to contribute to the Plan on behalf of Employees on substantially the same basis upon which other participating Employers are contributing to the Plan;
2. are accepted for participation in the Plan by the Trustees; and
3. make contributions to the Plan as required by the Participation Agreement.

**Contributions** shall mean payments made by the signatory Employer(s) to the Fund for benefits under this Plan.

**Copayment or Copay** shall mean the Covered Person's portion of the payment for benefits indicated in the Schedule of Benefits. This payment may be requested at the time of service. Copayments do not count toward the satisfaction of Deductibles or Out-of-Pocket Maximums.

**Copercentage or Coinsurance** shall mean the percentage of a Covered Expense that a Covered Person pays after the satisfaction of any applicable Deductible.

**Cosmetic Treatment** shall mean medical or surgical procedures to alter normal structures of the body, as determined by the Plan, in order to improve appearance, treat a Mental Health Disorder or to improve self-esteem.

**Covered Expenses** shall mean those expenses listed as covered in the Covered Medical Expenses Article.

**Covered Person** shall mean a Participant or Dependent covered under the Plan.

**Creditable Coverage** shall mean only those coverages required to be included as such under Section 2701(c) of the Public Health Services Act, and shall exclude those coverages that are permitted to be excluded under Section 2701(c). Solely for purposes of illustration and not in limitation of the foregoing, Creditable Coverage generally includes periods of coverage under an individual or group health plan that are not followed by a Significant Break in Coverage and excludes coverages for liability, limited scope dental or vision benefits, specified disease and/or other supplemental type benefits. *Creditable Coverage* means coverage under the following:

1. A group health plan;
2. Health insurance or Health Maintenance Organization coverage;
3. Medicare;
4. Medicaid;
5. Military health care;
6. A medical care program of the Indian health Services or of a tribal organization;
7. A state health benefits risk pool;



8. A health plan offered under the Federal Employee Health Benefits Program;
9. A public health plan as defined under Federal regulations; or
10. A health benefit plan under Section 5(e) of the Peace Corps Act.

Creditable Coverage applies where the previous coverage was in effect at any time during the 12 months preceding the Effective Date. Any Waiting Period that applied before the Creditable Coverage became effective will be credited.

**Custodial Care** shall mean non-medical aid consisting of services and supplies, provided to an individual in or out of an institution, primarily to assist such person in Activities of Daily Living, whether or not Disabled.

**Day Treatment or Partial Hospitalization** shall mean an Outpatient treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting, 20 or more daytime hours or 12 or more evening hours per week. The program is designed to treat patients with serious mental health and chemical dependency disorders and offers major diagnostic, psycho-social and prevocational modalities. Such programs must be in a less restrictive, less expensive alternative to Inpatient treatment.

**Deductible** shall mean Covered Expenses which are paid by the Covered Person each Calendar Year prior to a benefit being payable by the Plan.

**Dental Applicable Plan Limit** shall mean expenses for services and supplies which are Medically Necessary but only to the extent that such expenses are reasonable. The Plan Administrator will make the determination that an expense is reasonable. The Plan pays at the 80<sup>th</sup> percentile of reasonable and customary in the general geographic area where the service is provided.

**Dental Practitioner or Dentist** shall mean an individual licensed as a dental practitioner acting within the scope of his license in the jurisdiction where services are provided; or a licensed Physician performing a dental service within the scope of his license in the jurisdiction where services are provided.

**Dependent** shall mean any person described below.

1. **Spouse.** An individual who meets the legal definition of a Spouse determined under either federal or state law. A common law spouse qualifies as a spouse under this Plan only if a Participant and his/her spouse deliver to the Plan Administrator a notarized affidavit evidencing their common law marital status.
2. **Child(ren).** Child(ren) shall mean the following:
  - a. Your natural child(ren) until they reach age 26.
  - b. Your stepchild(ren), meaning your Spouse's child(ren) until they reach age 26 or earlier if your marriage to their natural parent ends other than due to the death of one of you.
  - c. Your adopted child(ren), meaning you or your Spouse have adopted such child(ren) or such child(ren) are placed for adoption with you until the child(ren) turns age 26. You or your Spouse must be one of the adopting parents, the child must have been placed in you or your Spouse's custody, and the adoption proceeding must have assigned the responsibility for benefits coverage to you or your Spouse.
  - d. Your child covered by a Qualified Medical Child Support Order ("QMCSO"), meaning your child(ren) on whose behalf a QMCSO has been entered or issued, indicating that coverage

must be provided by you until the child covered by the QMCSO is no longer so covered or turns 26 years of age, whichever occurs first.

- e. Continued coverage is provided for your child(ren) or other eligible dependent(s) who is physically or mentally incapable of self-support while remaining incapacitated, as long as you remain an Eligible Person and so long as (i) the child or other eligible dependent was enrolled in the Plan prior to his or her turning 26 years of age (for natural, adopted and stepchildren), or attaining age 25 (for other eligible dependents), as the case may be, and remained covered through such age; and (ii) the child or other eligible dependent satisfies the criteria for eligibility under one of the categories described above but for her or her age.

The coverage for children will end on the last day of the month in which the limiting age is reached.

This coverage does not include benefits for grandchildren.

3. In addition to the above limitations, Dependent does not include the spouse or child if eligible for coverage under the Plan as an Employee.

For purposes of coverage under this Plan, if both parents are Participants, a Dependent shall only be covered as a Dependent under this Plan by one parent.

The term Dependent will also include individuals who no longer meet the definition of a Dependent but are covered under COBRA.

**Disability** shall mean any congenital or acquired physical or mental illness, defect or characteristic preventing or restricting an individual from participating in normal life, or limiting the individual's capacity to work. Such Disability must be certified by a Physician.

**Durable Medical Equipment** shall mean equipment prescribed by a Physician which meets all of the following requirements:

4. Is Medically Necessary;
5. Is primarily and customarily used to serve a medical purpose;
6. Is designed for prolonged and repeated use;
7. Is for a specific therapeutic purpose in the treatment of an Illness or Injury;
8. Would have been covered if provided in a Hospital; and
9. Is appropriate for use in the home.

**Effective Date** shall mean the first day of coverage under this Plan as set forth in Article 4 for Participants and Dependents.

**Eligible Person** shall mean a person satisfying the criteria in Article 4.

**Emergency Medical Condition** shall mean a serious medical condition which arises suddenly and requires immediate care and treatment in order to avoid jeopardy to the life, health or ability to function of the person.

**Emergency Care Facility, Emergency Room or Urgent Care Facility** shall mean a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life time support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Emergency

Care Facility, by whatever actual name it is called; however, an after-hours clinic shall be excluded from the terms of this definition.

**Employee** shall mean an active member of the Union who is employed by a Contributing Employer and not engaged in Competitive Employment. The term Employee will also include former Employees covered under COBRA and, except where the context otherwise requires, Non-Bargaining Employees.

**Employer** shall mean any signatory employer that has signed a collective bargained agreement with Plumbers and Pipefitters Local Union 344.

**ERISA** shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

**Experimental Procedure.** Except as otherwise provided in this document, Experimental Procedure shall mean any drug, device, procedure, service or treatment that is the subject of ongoing Phase I, II or III clinical trials to determine maximum tolerated dose, toxicity, safety, or efficacy as compared to other treatments. A drug, device, procedure, service or treatment will be considered to be the subject of ongoing Phase I, II or III clinical trials to determine maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared to other treatments unless all of the following criteria are met:

1. *The drug, device, procedure, service or treatment must have approval from the appropriate government regulatory bodies.*

A drug, device, procedure, service or treatment must have Food and Drug Administration (“FDA”) approval for those specific indications and methods of use for which such drug, device, procedure, service or treatment is sought to be provided.

Any drugs, devices, procedures, services or treatments, which at the time sought to be provided are not approved by the Health Care Financing Administration for reimbursement under Medicare, are considered Experimental Procedures.

Drugs are considered experimental if they are not commercially available for purchase, and are not approved by FDA for general use. The phrase “approved by FDA for general use” refers to permission for commercial distribution. Any other approvals that are granted as an interim step in the FDA regulatory process are considered Experimental Procedures.

Drugs and tests approved by the FDA for a specific disease, illness, injury or condition, but which are sought to be provided for another disease, illness, injury or condition, are considered Experimental Procedures, except when the drug is used for the treatment of cancer and the American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information or the Compendia-Based Drug Bulletin recognizes it as an appropriate treatment for that form of cancer.

Drugs that are without at least one ingredient that constitutes a controlled substance as defined by the FDA are considered Experimental Procedures.

2. *The scientific evidence must permit conclusions concerning effect of the drug, device, procedure, service or treatment on health outcomes.*

The evidence must consist of well-designed and well-conducted investigations published in peer-review journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

The evidence must demonstrate that the drug, device, procedure, service or treatment can measure or alter the sought-after changes related to the disease, illness, injury or condition. In

addition, there must be evidence or a convincing argument based on established medical facts that such measurement or alteration affects that health outcome.

Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale.

3. *The drug, device, procedure, service or treatment must improve or contribute to the improvement of the net health outcome.*

The drug, device, procedure, service or treatment's beneficial effects on health outcomes must outweigh any harmful effects on health outcomes.

4. *The drug, device, procedure, service or treatment must be as beneficial as any established alternatives.*

The technology must improve the net health outcome as much or more than established alternatives.

5. *The improvement must be attainable outside the investigational settings.*

When used under the usual conditions of medical practice, the drug, device, procedure, service or treatment must reasonably be expected to satisfy criteria (a) and (b) and must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

Notwithstanding any other provision contained herein, these criteria will be the sole means to construe and determine whether any drug, device, procedure, service or treatment constitutes "Experimental Procedures."

**Extended Care Facility** shall mean an institution which:

6. Is duly licensed as an Extended Care Facility, convalescent facility, or Skilled Nursing Facility and operates in accordance with governing laws and regulations;
7. Regularly provides Inpatient Skilled Nursing Care for payment during the active or convalescent stage of an illness or injury;
8. Operates in accordance with medical policies, whereby such policies are supervised and established by a Physician other than the patient's own Physician;
9. Regularly maintains a daily medical record for each patient;
10. Is not, other than incidentally, a place for the aged, a place for individuals addicted to drugs or alcohol, or a place for Custodial Care; and
11. Is recognized as an Extended Care Facility or a Skilled Nursing Facility under Medicare.

**Family** shall mean a Participant and Covered Dependents.

**Fiduciary** shall mean a person who has discretionary authority or control over the administration or management of the Plan.

**FMLA** shall mean the federal Family and Medical Leave Act of 1993, which allows eligible employees of covered employers to take up to 12 weeks of certain unpaid, job-protected family and medical leave each year.

**Fund** shall mean the trust used to fund the benefits provided by the Plan.

**Geographical Region** means the Physicians Fee Reference (“PFR”) 5-digit zip code prefix adjustment factors (“multipliers”).

**Habilitative Services** shall mean services which are educational in scope and purpose and are rendered to develop, improve or accelerate functions that have never been present or are not present to the normal degree of a person of like age or sex, including for the treatment of autism.

**Home Health Care Agency** shall mean any of the following:

1. A Home Health Care agency licensed by the jurisdiction in which it is located,
2. A home health agency as defined by the Social Security Administration, or
3. An organization licensed in the jurisdiction in which it is located which is an appropriate provider of home health services, and which meets the following requirements:
  - a. Has a full-time administrator;
  - b. Keeps written medical records; and
  - c. Has at least one Registered Nurse (R.N.) on staff, or the services of an R.N. available.

**Home Health Care or Home Health Care Services** shall mean the following care provided to the Covered Person at the Covered Person’s home or a Home Health Care Agency on recommendation of a Physician:

1. Intermittent care by a:
  - a. Registered Nurse (R.N.)
  - b. Licensed Practical Nurse (L.P.N.)
  - c. Home Health Aide
  - d. Occupational and Physical Therapist
  - e. Licensed Vocational Nurse (L.V.N.)
  - f. Physical Therapist Assistant (P.T.A.)
  - g. Certified Occupational Therapist Assistant (C.O.T.A.)
2. Private duty nursing services of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);
3. Social work; and
4. Nutrition services, including special meals.

**Hospice** shall mean a public agency or a private organization which provides care and services for terminally ill persons and their families. Such agency or organization must be qualified to receive Medicare payments, or satisfy the following requirements:

1. Provides and has available 24 hours per day:
  - a. Palliative and supportive care for terminally ill persons,
  - b. Services which encompass the physical, psychological and spiritual needs of terminally ill persons and their families; and
  - c. Acute Inpatient Care, Outpatient Care, and Home Health Care. Care and Counseling must be furnished directly by, or under the arrangement of such agency or organization;
2. Has a medical director who is a Physician;

3. Has an interdisciplinary team to coordinate care and services, which includes at least one Physician, one R.N. and one social worker; and
4. Is licensed or accredited as a Hospice, if the laws of the jurisdiction in which it is located allow for the licensing or accreditation of Hospices.

**Hospice Care** shall mean care rendered by a Hospice in response to the special physical, psychological and spiritual needs of terminally ill Covered Persons and/or their Family members.

**Hospital** shall mean an institution which makes charges and is engaged primarily in providing Medical Care to sick and injured persons on an Inpatient basis at the patient's expense which fully meets all the requirements set forth below:

1. It is an institution operating in accordance with the law of the jurisdiction in which it is located pertaining to institutions identified as Hospitals. It is primarily engaged in providing Medical Care of injured and sick persons by or under the supervision of a staff of physicians or surgeons for compensation from its patients on an Inpatient basis. It continuously provides 24 hour nursing services by Registered Nurses, maintains facilities on the premises for major operative surgery. It is not, other than incidentally, a nursing home, a place for rest, a place for the aged, a place for the mentally ill or emotionally disturbed, or a place for the treatment of substance use disorder.
2. It is accredited by the Joint Commission of Accreditation of Hospitals ("JCAH") or is recognized by the American Hospital Association ("AHA") and is qualified to receive payments under the Medicare program.
3. It is a psychiatric hospital, as defined by Medicare, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare.

**Hour Bank Account** shall mean an account of hours established in your name by the Fund or Plan. Subject to the maximum limit of 780 hours, all hours worked for a Contributing Employer for which Contributions are made on your behalf will be credited to your Hour Bank Account

**Illness** shall include disease, Mental Health Conditions, and pregnancy.

**Incurred Charges or Incurred** shall mean charges for services or supplies that are actually received. A charge shall be considered an Incurred Charge on the date the supplies or services are actually received.

**Injury** shall mean only bodily Injury.

**In-Network** shall mean the services or supplies provided by a Participating Provider, or authorized by any of the Plan's contracted Networks.

**Inpatient** shall mean a registered bed patient in a Hospital or Other Facility Provider and for whom a room and board charge is made. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

**Inpatient Care** shall mean Medical Care provided to an Inpatient.

**Late Enrollee** shall mean a Participant or Dependent who, or a Dependent for whom the responsible Participant fails to enroll during the periods set forth in the Enrollment, Eligibility and Contributions Article. A Special Enrollee shall not be considered a Late Enrollee.

**Leased Employee** shall mean leased employee as defined in Section 414(n) of the Internal Revenue Code, all independent contractors and all other individuals whom the Employer does not treat as its employees for federal income and employment tax purposes, even if it is subsequently determined by a court or the

Internal Revenue Service that such individuals should be, or should have been, properly classified as common law employees of the Employer.

**Lifetime Maximum or Lifetime Maximum Benefit** shall mean the maximum amount to be paid by the Plan on behalf of a Covered Person for Covered Expenses which are Incurred while such Covered Person is covered under the Plan.

**Medical Care** shall mean professional services rendered by a Physician or Other Professional Provider for the treatment of an Illness or Injury.

**Medical Case Management** shall mean a program in which a case manager monitors the Covered Person to explore and discuss alternate or other coordinated types of Medical Care available.

**Medical Emergency or Emergency** shall mean medical services and supplies provided after the sudden onset of a medical condition (Illness or Injury) manifesting itself by acute symptoms including intense pain, which are severe enough that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. The patient's health would be in serious jeopardy;
2. Bodily function would be seriously impaired; or
3. There would be serious dysfunction of a bodily organ or part.

**Medical Management** shall mean the company appointed by the BOT to provide the utilization management and medical case management.

**Medically Necessary or Medical Necessity** shall mean the drug, device, procedure, service, treatment or supplies which are required to identify or treat a Covered Person's Illness or Injury and which are:

1. Commonly and customarily recognized by the medical profession as appropriate care consistent with the symptom or diagnosis and treatment of the Illness or Injury;
2. Appropriate with regard to standards of sound medical practice;
3. Not primarily Custodial Care;
4. Services that could not have been omitted without adversely affecting the Participant's condition or the quality of Medical Care rendered;
5. Not solely for the convenience of a Participant, Physician, Hospital or Other Facility Provider;
6. The most appropriate supply or level of service which can be safely provided to the Participant, or for an Inpatient, as the Participant's medical symptoms or condition require, and that the services cannot be safely provided to the Participant as an Outpatient; and
7. Not including unnecessary repeated tests.

**Note:** Although a Physician or Other Professional Provider may have prescribed treatment, such treatment may not be considered Medically Necessary within this definition.

**Right to Choose.** The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a Covered Expense, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if the provider is Out-of-Network, the Covered Person still has the right and privilege to utilize such provider at the Plan's reduced

Copercantage level with the Covered Person being responsible for a larger percentage of the total medical expense.

**Medicare** shall mean Title XVII of the United States Social Security Act, as amended, and the Regulations promulgated thereunder.

**Medicare Entitlement** under COBRA shall mean a person who is eligible for Medicare and has actually become enrolled in Medicare.

**Mental Health Conditions** shall mean any mental health condition as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, which is caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, and autism.

**Morbid Obesity** shall mean any of the following:

1. A weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables;
2. A body mass index ("BMI") equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
3. A BMI of 40 kilograms per meter squared without such comorbidity.

As used herein, BMI equals weight in kilograms divided by height in meters squared.

**Named Fiduciary** shall mean the Board of Trustees.

**Network** shall mean any preferred provider or managed care network under contract with the Plan to provide or arrange to provide services or supplies to Covered Persons.

**Non-Bargaining Employee** shall mean an employee of the Union, the Fund, the Union JATC, or a participating employer (who has a valid and signed participation agreement in place) who is not a member of the Union. A Non-Bargaining Employee may include, but is not limited to, office, clerical, executive, supervisory, and estimator employees. Any provisions herein regarding an Hour Bank Account do not apply to Non-Bargaining Employees, and no hours will accrue for Non-Bargaining Employees.

**Open Enrollment Period** shall mean a period of time designated by the Board of Trustees. The Open Enrollment Period may vary from year to year.

**Other Facility Provider** shall mean any of the following:

1. Ambulatory Care Facility,
2. Substance use disorder treatment facility,
3. Free-standing dialysis facility,
4. Outpatient psychiatric facility,
5. Psychiatric day treatment facility,
6. Psychiatric Hospital, Hospice,
7. Extended Care Facility,



8. Rehabilitation Hospital, which is licensed as such in the jurisdiction in which it is located, or
9. Urgent Care Facility.

**Other Professional Provider or Professional Provider** shall mean the following persons or practitioners, including Physicians, acting within the scope of such provider's license which is certified and licensed in the jurisdiction in which the services are provided:

1. Anesthesiologist
2. Audiologist
3. Certified Nurse Practitioner
4. Clinical Social Worker
5. Dental Practitioner
6. Emergency Medical Technician
7. Independent Laboratory Technician
8. Licensed Practical Nurse
9. Nurse Midwife
10. Occupational Nurse
11. Pharmacist
12. Physician Assistants
13. Physical Therapist
14. Physical Therapist Assistant
15. Registered Nurse
16. Respiratory Therapist
17. Speech Language Pathologist
18. Occupational Therapist
19. Certified Occupational Therapy Assistant

**Out-of-Network** shall mean drugs, devices, procedures, services, treatments or supplies which are not provided by a Participating Provider or the subject of any of the Plan's Network contracts. Out-of-Network charges are subject to the Applicable Plan Limit.

**Out-of-Pocket Expense** shall mean any amount of Deductible and Copayment that the Covered Person pays for any Covered Expense.

When the total of all eligible Out-of-Pocket Expenses Incurred during one Calendar Year by:

1. One Covered Person; or
2. Covered members of a Family reach their limit specified in the Schedule of Benefits,

the Plan covered percentage will automatically increase to 100% for any additional Covered Expenses Incurred during that Calendar Year.

**Note:** Certain payments cannot be applied toward the Out-of-Pocket Limit. See Schedule of Benefits.

**Out-of-Pocket Limit or Out-of-Pocket Maximum** shall mean the maximum amount of Deductible and Copayment during any Calendar Year that the Covered Person or Family shall pay before the Plan shall pay 100% of Covered Expenses for that Calendar Year.

**Outpatient** shall mean a Covered Person who receives drugs, devices, procedures, services, treatments or supplies while not confined as an Inpatient.

**Outpatient Care** shall mean Medical Care provided to a Covered Person while the Covered Person is an Outpatient.

**Outpatient Surgery** shall mean surgical services provided to the Covered Person while the Covered Person is an Outpatient.

**Part Time Employee** shall mean an employee regularly scheduled to work at a position for less than 40 hours per week.

**Participant** shall mean an Employee who meets the requirements for eligibility, properly enrolls in the Plan, and continuously meets the requirements for eligibility.

**Participating Physician** shall mean a duly licensed Physician under contract with any of the Plan's contracted Networks.

**Participating Provider** shall mean any Hospital, Physician, pharmacy, Other Professional Provider, Other Facility Provider or other entity under contract with the Plan's contracted Network. The participation status may change from time to time. Refer to the Provider Directory or contact the Preferred Provider Organization for a listing of the Participating Providers.

**PHI or Protected Health Information** shall mean information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. PHI includes information of persons living or deceased.

**Physician** shall mean a properly licensed person holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.) or Doctor of Chiropractic (D.C.).

**Plan, The Plan or This Plan** shall mean the Plumbers and Pipefitters Local Union 344 Health and Welfare Plan.

**Plan Administrator** shall mean the Board of Trustees.

**Plan Document** shall mean this Plan Document and Summary Plan Description.

**Plan Sponsor** shall mean the Board of Trustees.

**Plan Year** shall mean January 1 through December 31 each year.

**Preauthorization or Preauthorize or Preauthorized** shall mean the pre-approval of a Covered Expense by the Preauthorization Provider listed in the Plan Identifying Information Section.

**Precertification or Precertify or Precertified** shall mean the process for a provider or Covered Person to notify the Plan of a Covered Person's treatment, as specified in Article 6.

**Prescription Drugs** shall mean drugs or medicines obtainable only upon a Physician's written prescription, including any medication compounded by the pharmacist that contains a prescription legend drug, insulin and insulin needles and syringes.

**Provider** means a physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, psychiatrist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, certified midwife, or Other Professional Provider, Other Facility Provider, or Other Person approved by the Plan Administrator.

**Qualified Beneficiary** under COBRA shall mean an individual who was covered by the Plan on the day before a Qualifying Event occurred that caused him or her to lose coverage under the Plan.

**Qualified Medical Child Support Order** shall mean a judgment, decree or order (issued by a court or through a state administrative process) that requires a group health plan to provide coverage to a Participant's child and meets other specific requirements as outlined by the Employer.

**Qualifying Event** under COBRA shall mean a triggering event that causes a loss of coverage under the Plan.

**Retiree** shall mean a former Employee who meets the requirements of Section 4.05(A). No other retirees are eligible for coverage under this Plan.

**Significant Break in Coverage** shall mean a period of 63 or more consecutive days without Creditable Coverage. Periods of no coverage during an HMO affiliation period or Waiting Period shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred. For this purpose, an HMO affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

**Skilled Nursing Care** shall mean service provided by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), provided the care is Medically Necessary and the treating Physician has prescribed such care.

**Skilled Nursing Facility** shall mean an institution which:

1. Is duly licensed as an Extended Care Facility or convalescent facility, and operates in accordance with governing laws and regulations;
2. Regularly provides Inpatient Skilled Nursing Care for payment during the active or convalescent stage of an Illness or Injury;
3. Is staffed with a Physician or Registered Nurse on duty 24 hours a day;
4. Operates in accordance with medical policies supervised and established by a Physician other than the patient's own Physician;
5. Regularly maintains a daily medical record for each patient;
6. Is not, other than incidentally, a place for the aged, a substance use disorder treatment facility, or a place for Custodial Care; and
7. Is recognized as an Extended Care Facility or a Skilled Nursing Facility under Medicare.

**Special Enrollee** under HIPAA shall mean an Employee or Dependent who is entitled to and who requests Special Enrollment as described in the Enrollment, Eligibility and Contributions Article.

**Special Enrollment** under HIPAA shall mean enrollment opportunities under the Plan other than normal Open Enrollment that occur due to certain situations.

**Specialist** shall mean Physicians who generally specialize in one field of medicine (*i.e.* Cardiologist, Neurologist).

**Specialty Drugs** shall mean those Prescription Drugs covered under the Specialty Drug Program.

**Specialty Pharmacy Program** shall mean the program described in Article 9, administered by MedTrak Pharmacy Services to help manage pharmaceutical expenses for certain Specialty Drugs.

**Spinal Manipulation Treatment** shall mean office visits or treatment which involve manipulation (with or without the application of treatment such as heat, water or cold therapy, diathermy or ultrasound) of the spinal skeletal system and/or surrounding tissues to allow free movement of joints, alignment of bones, or enhancement of nerve functions.

**Spouse** shall mean a person married to an Employee in a ceremony recognized by the law of the state in which it was performed. The term Spouse shall also include a common law spouse if the state in which the parties reside at the time of the common law marriage was created recognizes common law marriage. The Plan Administrator may require proof of the common law marriage, as it from time to time determines.

**Substance Use Disorder** shall mean the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal. The Plan does not provide benefits for Substance Use Disorder.

**Support** shall mean, for purposes of coverage under this Plan, the Participant providing over 50% of the child's living expenses.

**Telemedicine** shall mean the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.

**Terminal Illness or Terminally Ill** shall mean a life expectancy of 6 months or less.

**Termination of Employment or Terminates Employment** shall mean the severance of an Employee's employment relationship with the Employer, or the expiration of an Approved Leave of Absence, or leave mandated by the Family and Medical Leave Act from the Employer without the Employee returning to the employment of such Employer.

**Union.** The term "Union" means the Plumbers and Pipefitters Local Union No. 344 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada and any local union(s) accepted for participation into the Fund by the Trustees.

**Urgent Care** shall mean medical care or treatment with respect to which the application of time could seriously jeopardize the Covered Person's life or health.

**USERRA** shall mean the Uniformed Services Employment and Reemployment Rights Act.

**Utilization Management** shall mean a process to review and determine the Medical Necessity and appropriateness of care and treatment proposed for Covered Persons.

**Waiting Period** shall mean the period that must pass under this Plan (or for purposes of determining Creditable Coverage, under any other group health plan) before an Employee or Dependent is eligible to enroll in the Plan (or other health plan as the case may be). Notwithstanding the foregoing, if an Employee

or Dependent enrolls as a Late Enrollee, or Special Enrollee on a Special Enrollment Date, any period before such late or Special Enrollment is not a Waiting Period.

**You or Your** shall mean the Participant.

**COVID-19 RELIEF ADDENDUM**  
**I. COVID-19 Diagnostic Services**

Notwithstanding any other provision of the Plan to the contrary, and until the end of the public health emergency declared by the Secretary of HHS, covered services includes in vitro or serological diagnostic tests for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that:

- (1) is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb-3);
- (2) the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 360bbb-3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;
- (3) is developed in and authorized by a state that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID-19; or
- (4) is another test determined appropriate by the Secretary of HHS in guidance.

Covered services includes items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described above, but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need of the individual for such product.

Such COVID-19 diagnostic tests and other items and services described above are covered at 100% with no cost-sharing (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements regardless of whether furnished by a Network Provider or Out-of-Network Provider.

Such COVID-19 diagnostic tests are also covered services when provided:

- through state- or locality-administered testing sites;
- at drive-through sites;
- at sites that do not require appointments;
- by point-of-care tests (i.e. “rapid” tests); and
- using at-home COVID-19 diagnostic tests when the test is ordered by an attending health care provider who has determined that the test is medically appropriate for the individual based on current accepted standards of medical practice and the test otherwise meets the requirements outlined above.

Additionally, the Plan also covers no more than two COVID-19 diagnostic tests per month for purposes of workplace safety or other purposes not primarily intended for individualized diagnosis.

The COVID-19 public health emergency expired on May 11, 2023. This COVID-19 Diagnostic Services section of the Plan expires after the end of the public health emergency, and COVID-19 diagnostic tests will be reimbursed as an outpatient diagnostic lab benefit at the applicable in-network or out-of-network cost-sharing rates outlined in the Schedule of Benefits above. Additionally, COVID-19 tests used for purposes of workplace safety and not primarily intended for individualized diagnosis will no longer be covered.

## **II. OTC At-Home Tests**

Effective as of January 15, 2022, the covered COVID-19 diagnostic tests identified above will also include tests purchased over-the-counter, including tests obtained without the involvement of a healthcare provider, as provided by “FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 52” published jointly by the Departments of Labor, Health and Human Services, and the Treasury.

Such COVID-19 diagnostic tests are covered at 100% with no cost-sharing (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements regardless of whether purchased from a preferred or non-preferred pharmacy.

Notwithstanding the above, effective as of January 15, 2022, tests purchased at non-preferred pharmacy locations are covered up to the lesser of (1) 100% of the cost of the test or (2) \$12 per test, inclusive of any taxes and shipping costs. No more than eight OTC COVID-19 tests will be covered each 30 days per Participant or Dependent.

Depending on where the test is purchased, you may be required to complete and submit a reimbursement form to the Plan’s PBM or claims administrator. Please contact the PBM, claims administrator, or the Plan Administrator for more information on preferred pharmacy locations and procedures for requesting reimbursement.

The COVID-19 public health emergency expired on May 11, 2023. This OTC At-Home Tests section of the Plan expires after the end of the public health emergency, and OTC COVID-19 diagnostic tests will no longer be covered by the Plan.

## **III. COVID-19-Related Telemedicine**

The Plan covers virtual primary and specialist care or telehealth visits, as well as Teladoc visits, that result in an order for, or administration of, a diagnostic test for COVID-19 are covered by the Plan at 100% with no deductible or other cost-sharing, regardless of a Provider’s network participation status.

Virtual/telehealth/Teladoc visits not related to COVID-19 continue to be covered at the Plan’s regular benefit level described elsewhere in this Plan document.

The COVID-19 public health emergency expired on May 11, 2023. This COVID-19-Related Telemedicine section of the Plan expires after the end of the public health emergency, and all telemedicine visits will be reimbursed as described elsewhere in the Plan.

## **IV. COVID-19 Preventive Services and Vaccines**

The Plan covers any item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is:

- (1) an evidence-based item or service that has in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; or
- (2) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

Coverage of such item, service, or immunization shall be effective 15 business days after the date on which such recommendation is made. Such item, service, or immunization will be covered at 100% with no cost-sharing (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements regardless of whether furnished by an In-Network Provider or Out-of-Network Provider. COVID-19 immunizations and their administration will be covered without cost-sharing even if

the administration of multiple doses is required and even if a third party, such as the federal government, pays for the preventive immunization.

The terms of this COVID-19 Preventive Services and Vaccines will automatically expire upon the end of the applicable public health emergency. Upon such expiration, COVID-19-related preventive services will be governed by the other applicable terms of the Plan.

#### **V. COVID-19 Extension of Deadlines**

Pursuant to the guidance issued by the Employee Benefits Security Administration in Disaster Relief Notice 2020-01 and the Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the Covid-19 Outbreak issued by the Department of Labor, the Department of the Treasury, and the Internal Revenue Service, both as amended by EBSA Disaster Relief Notice 2021-01, certain deadlines under the Plan are deemed extended.

Notwithstanding any other provision of the Plan to the contrary, the Plan will disregard the period beginning March 1, 2020, until the earlier of (a) one year from the date the disregarded period began or (b) 60 days after the announced end of the National Emergency (i.e. the end of the Outbreak Period) or such other date as required by federal legislation or agency guidance. In no case will an individual disregarded period exceed one year. Such extensions are provided on an individualized basis.

This deadline extension applies to the following, as applicable to the Plan:

- (a) the 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA § 701(f) and Code § 9801(f);
- (b) the 60-day election period for COBRA continuation coverage under ERISA § 605 and Code § 4980B(f)(5);
- (c) the date for making COBRA premium payments pursuant to ERISA §§ 602(2)(C) and (3) and Code §§ 4980B(f)(2)(B)(iii) and (C);
- (d) the date for individuals to notify the Plan of a qualifying event or determination of disability under ERISA § 606(a)(3) and Code § 4980B(f)(6)(C);
- (e) the date within which individuals may file a benefit claim under the Plan's claims procedures pursuant to 29 CFR § 2560.503-1;
- (f) the date within which claimants may file an appeal of an adverse benefit determination under the Plan's claims procedures pursuant to 29 CFR § 2560.503-1(h);
- (g) the date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination pursuant to 29 CFR § 2590.715-2719(d)(2)(i) and 26 CFR § 54.9815-2719(d)(2)(i);
- (h) the date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 CFR § 2590.715-2719(d)(2)(ii) and 26 CFR § 54.9815-2719(d)(2)(ii); and
- (i) the date for providing a COBRA election notice under ERISA § 606(c) and Code § 4980B(f)(6)(D).



## NO SURPRISES ACT ADDENDUM

**Addendum Effective Date:** This No Surprises Act Addendum (this “Addendum”) is effective as of January 1, 2022.

The terms of this Addendum supersede any contrary terms of the Plan to which this Addendum is attached unless otherwise required by Federal or applicable state law. However, definitions set forth in this Addendum are for purposes of this Addendum only, and capitalized words in this Addendum that are not defined in this Addendum have the same meaning ascribed to them in the full Plan document. Additionally, for purposes of this Addendum, references to You and Your mean any Covered Person.

### I. Continuity of Care

If you are under the care of a Participating Provider who stops participating in the Plan’s network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that Provider’s covered services at the In-Network benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition;
2. You are undergoing institutional or inpatient care;
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery);
4. You are pregnant or undergoing a course of treatment for Your pregnancy; or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies you of the Provider’s termination, or any longer period provided by applicable state law. If You are in the second or third trimester of pregnancy when the Provider’s termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for benefits under this provision, as explained in the Plan.

### II. Federal No Surprises Act

#### 1. Definitions

The definitions below apply only to this Addendum.

“Air Ambulance Services” means, for purposes of this Addendum only, medical transport by helicopter or airplane for patients.

“Emergency Medical Condition” means, for purposes of this Addendum only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the

absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or, with respect to a pregnant woman, her unborn child, in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

“Emergency Services” means, for purposes of this Addendum only,

- a medical screening examination performed in the emergency department of a hospital or an Independent Freestanding Emergency Department;
- further medical examination or treatment you receive at a Hospital, regardless of the department of the Hospital, or an Independent Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- covered services you receive from a Non-Participating Provider during the same visit after your Emergency Medical Condition has stabilized unless:
  - Your Non-Participating Provider determines you can travel by non-medical or non-emergency transport;
  - Your Non-Participating Provider has provided you with a notice to consent form for balance billing of services; and
  - You have provided informed consent.

“Non-Participating Provider” means, for purposes of this Addendum only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with the Plan for furnishing such item or service under the Plan to which this Addendum is attached.

“Non-Participating Emergency Facility” means, for purposes of this Addendum only, with respect to a covered item or service, an emergency department of a hospital or an Independent Freestanding Emergency Department that does not have a contractual relationship with the Plan for furnishing such item or service under the Plan to which this Addendum is attached.

“Participating Provider” means, for purposes of this Addendum only, with respect to a covered service, a physician or other health care provider who has a contractual relationship with the Plan setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Addendum is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

“Participating Facility” means, for purposes of this Addendum only, with respect to covered service, a hospital or ambulatory surgical center that has a contractual relationship with the Plan setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Addendum is attached.

“Qualifying Payment Amount” means, for purposes of this Addendum only, a median of contracted rates calculated pursuant to federal or state law, regulation, and/or guidance.

“Recognized Amount” means, for purposes of this Addendum only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no applicable state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

## **2. Federal No Surprises Act Surprise Billing Protections**

### **a. Included Services**

The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections (“Included Services”) are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

### **b. Claim Payments**

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

### **c. Cost-Sharing**

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate your cost-share requirements, including Deductibles, Copayment Amounts, and Coinsurance Amount.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate your cost-share requirements, including Deductibles, Copayment Amounts, and Coinsurance Amount, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your in-network Deductible and/or Out-of-Pocket Maximum, if any.

## **3. Prohibition of Balance Billing**

You are protected from balance billing on Included Services as set forth below.

If you receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill you is your in-network cost-share. You cannot be balance billed for these Emergency Services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill you is your Plan’s in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can’t balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at Participating Facilities, Non-Participating Providers can’t balance bill you unless you give written consent and give up your protections.

If your Plan includes Air Ambulance Services as a covered service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill you is your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

**NOTE: The revisions to your Plan made by this Addendum are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Addendum, the regulations and any additional guidance will control over conflicting language in this Addendum.**

## NOTICE UNDER FEDERAL LAW

### **Newborns and Mothers Health Protection Act**

**Notice.** Under federal law, group health plans and health insurance issuers offering group health insurance, generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother of the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., your Physician, nurse or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits for Out-of-Pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan may not, under federal law, require that a Physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your Out-of-Pocket costs, you may be required to obtain Precertification. For information on Precertification, contact the Plan Administrator or the Precertification Provider.

### **Women's Health and Cancer Rights Act**

**Notice.** On January 1, 1999, a new federal law, the Women's Health and Cancer Rights Act of 1998, became effective for the Plan. The law requires group health plans to provide coverages for mastectomies and to also provide coverage for reconstructive surgery and prosthesis following mastectomies. The law mandates that a Participant or Dependent who is receiving benefits on or after the law's effective date for a mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

1. Reconstruction of the breast on which a mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prosthesis and treatment of physical complications of all stages of mastectomies, including lymphedemas.

This coverage will be provided in consultation with the Covered Person and the Covered Person's attending Physician and will be subject to the same annual Deductible, Copcentage and/or Copayment provisions otherwise applicable under the Plan. If you have any questions about coverages for mastectomies and post-operative reconstructive surgery, please contact the Plan Administrator.

## **Medicare Part D Notice**

### **Notice from Plumbers and Pipefitters Local Union 344 Health and Welfare Plan Health Benefits Program about Your Coverage and Medicare.**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Plumbers & Pipefitters Local 344 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Plumbers & Pipefitters Local 344 has determined that the prescription drug coverage offered by Plumbers & Pipefitters Local 344's plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

#### **When Can You Join a Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

#### **What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your current Plumbers & Pipefitters Local 344 coverage will be affected. For individuals who elect Part D coverage, Plumbers & Pipefitters Local 344 prescription drug coverage will end. If you do decide to join a Medicare drug plan and drop your current Plumbers & Pipefitters Local 344 coverage, be aware that you and your dependents will not be able to get this coverage back.

#### **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with Plumbers & Pipefitters Local 344 and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact Plumbers & Pipefitters Local 344 at the phone number shown below for further information. *NOTE:* You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Plumbers & Pipefitters Local 344. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription drug coverage:

1. Visit [www.medicare.gov](http://www.medicare.gov).
2. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of "Medicare & You" handbook for their telephone number) for personalized help

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender: Plumbers & Pipefitters Local 344

Contact/Office: Benefits Office

Address: 4337 SW 44<sup>th</sup> St. Oklahoma City, OK 73119

Phone Number: 405-682-4581

## **COBRA Rights Notice**

You are receiving this notice because you have recently become eligible for coverage under the Plumbers & Pipefitters Local 344 health plan (the Plan). This notice contains important information about your right to COBRA Continuation Coverage, which is a temporary extension of coverage under the Plumbers & Pipefitters Local 344 Plan. This notice generally explains COBRA Continuation Coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review your Summary Plan Description or contact the Plumbers & Pipefitters Local 344 Benefits Office.

### **What Is COBRA Continuation Coverage?**

COBRA Continuation Coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event occurs, COBRA Continuation Coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA Continuation Coverage must pay for that coverage.

You will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

Your spouse will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events happens:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- Your death;
- Your entitlement to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated.

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

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- Your death;



- Your entitlement to Medicare benefits (under Part A, Part B or both);
- Your divorce or legal separation; or
- The dependent stops being eligible for coverage under the Plan as a “dependent child.”

**When Is COBRA Coverage Available?**

Plumbers & Pipefitters Local 344 will offer COBRA Continuation Coverage to qualified beneficiaries only after it has been notified that a qualifying event occurred. For the following qualifying events, Plumbers & Pipefitters Local 344 will automatically process the qualifying event:

- Your hours of employment are reduced;
- Your employment ends;
- Your death; or
- Your entitlement to Medicare benefits (under Part A, Part B or both).

**You Must Give Notice of Some Qualifying Events**

For the following qualifying events, you or a family member must notify the Plumbers & Pipefitters Local 344 Benefits Office within 60 days after the qualifying event occurs:

- Your divorce or legal separation; or
- Your dependent’s loss of eligibility for coverage as a “dependent child.”

You must notify Plumbers & Pipefitters Local 344 of the qualifying event by calling the Plumbers & Pipefitters Local 344 Benefits Office at (405) 682-4581.

**How Is COBRA Coverage Provided?**

Once Plumbers & Pipefitters Local 344 receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage. You may elect Continuation Coverage on behalf of your spouse and dependent children. Your spouse may also elect Continuation Coverage on behalf of your dependent children.

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is one of the following events, COBRA Continuation Coverage lasts for up to a total of 36 months for your spouse and dependent children:

- Your death;
- Your divorce or legal separation; or
- Your dependent stops being eligible for coverage under the plan as a “dependent child.”

When the qualifying event is one of the following events, COBRA Continuation Coverage lasts for up to a total of 18 months for qualified beneficiaries:

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

When the qualifying event is your reduction in hours or your termination of employment and you were entitled to Medicare benefits prior to the qualifying event, additional coverage for your spouse and dependents may be available. Your spouse and dependents would be eligible to receive up to 36 months of COBRA Continuation Coverage from the date of your entitlement to Medicare. For example, if you became entitled to Medicare eight months before the date your employment terminates, COBRA Continuation Coverage for your spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months prior to the qualifying event).

**There are two ways in which an 18-month period of COBRA Continuation Coverage can be extended.**

**Disability Extension of 18 -Month Period of Continuation Coverage**

COBRA coverage may be available for you and your family up to a total of 29 months at a higher premium if:

- You, your covered spouse or your covered dependents (including newborn and newly adopted children) are determined to be disabled, as defined by the Social Security Act, prior to the qualifying event or during the first 60 days of COBRA coverage;
- The Social Security Administration's disability determination is received within the disabled individual's 18 months of COBRA coverage;
- The disability lasts at least until the end of the 18-month period of Continuation Coverage; and
- Plumbers & Pipefitters Local 344 is notified of the Social Security Administration's disability determination within 60 days of the disabled individual's receipt of a Social Security Disability award. If the disability determination occurred before COBRA coverage started, you're required to notify Plumbers & Pipefitters Local 344 within the first 60 days of COBRA coverage.

You, your covered spouse or your covered dependents must notify Plumbers & Pipefitters Local 344 within 60 days of receipt of the disability determination and prior to the end of the initial 18-month continuation period in order to receive the coverage extension. To notify Plumbers & Pipefitters Local 344 of the disability determination, call 405-682-4581.

You, your covered spouse or your covered dependents must notify Plumbers & Pipefitters Local 344 within 30 days of the date the disability ends by calling the Benefits Office at 405-682-4581.

**Second Qualifying Event Extension of 18 -Month Period of Continuation Coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA Continuation Coverage, your spouse and dependent children can receive up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months. Additional Continuation Coverage is available only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. These events include:

- Your death;
- Your entitlement to Medicare (under Part A, Part B or both);
- Your divorce or legal separation; or
- Your dependent stops being eligible for coverage under the plan as a "dependent child."

You, your covered spouse or your covered dependents must notify Plumbers & Pipefitters Local 344 within 60 days after the event occurs in order to receive this additional coverage. To notify Plumbers & Pipefitters Local 344 of the qualifying event, call 405-682-4581.

### **Events That May Change Continued Coverage**

Once your COBRA coverage begins, you may be able to change your COBRA coverage elections based on plan rules

if you experience a qualified change in status. You, your covered spouse or your covered dependents must notify Plumbers & Pipefitters Local 344 by calling 405-682-4581 within 60 days of the qualified change in status to change your COBRA coverage. See your Summary Plan Description for detailed information on allowable changes in status. Adding family members to COBRA coverage may result in a higher premium for this additional coverage.

You may also change COBRA coverage if a child is born to the covered employee or placed for adoption with the covered employee during the 18, 29 or 36-month continuation period. In such case, you must notify Plumbers & Pipefitters Local 344 by calling 405-682-4581 within 60 days of the birth or placement to cover the new dependent as a qualified beneficiary under COBRA. There may be a higher premium for this additional coverage.

### **Events That End Continued Coverage**

COBRA coverage will end automatically upon the expiration of the 18, 29 or 36-month continuation periods described on the previous pages. In addition, COBRA coverage will end automatically if any of the following situations occur:

- Plumbers & Pipefitters Local 344 stops providing group health benefits;
- Premiums are not paid within 30 days of the due date (with the exception of the initial premium which is due within 45 days of your election date); or
- A person eligible for continued benefits becomes covered under any other group health plan (unless the health plan has an enforceable pre-existing condition clause) or becomes entitled to Medicare.

If your coverage ends because of expiration of the 18, 29 or 36-month limit, you may be able to convert coverage to an individual policy if this right currently exists in the Plan.

### **Address Information**

Be sure to keep your current address information up to date with Plumbers & Pipefitters Local 344. Doing so is the only way to ensure that important benefit information will reach you.

### **Your Rights Under ERISA**

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

**For More Information**

If you have any questions about COBRA Continuation Coverage, call the Plumbers & Pipefitters Local 344 Benefits Office at 405-682-4581.

If you need additional information about your Plumbers & Pipefitters Local 344 health coverage, call the Plumbers & Pipefitters Local 344 Benefits Office at 405-682-4581.