

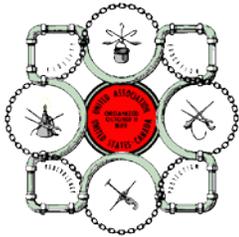
**PLUMBING AND PIPEFITTING INDUSTRY  
HEALTH AND WELFARE FUND OF KANSAS**  
505 S BROADWAY, STE 117  
WICHITA KS 67202-3922  
Phone (316) 264-2339

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## **IMPORTANT NOTICE**

**THE FOLLOWING PAGES ARE CHANGES THAT HAVE BEEN  
MADE TO THE PLAN SINCE THE BOOK WAS LAST PRINTED.**

**PLEASE KEEP THESE WITH YOUR GROUP BENEFIT PLAN  
BOOK ENCLOSED FOR FUTURE REFERENCE.**



**PLUMBING AND PIPEFITTING INDUSTRY  
HEALTH AND WELFARE FUND OF KANSAS**  
505 S BROADWAY, STE 117  
WICHITA KS 67202-3922  
Phone (316) 264-2339

December 2017

**To: All Plan Participants and Dependents  
Plumbing and Pipefitting Industry Health and Welfare Plan of Kansas**

**PARTICIPANT NOTICE**

This Participant Notice will advise you of certain material modifications that have been made to the Plumbing and Pipefitting Industry Health and Welfare Plan of Kansas. This information is VERY IMPORTANT to you and your dependents. Please take the time to read it carefully.

**Out-of-Pocket Maximum**

The Plan's out-of-pocket maximums have been revised in an effort to maintain the Plan's financial strength. The out-of-pocket maximum is the most that you could pay in a year for covered services. If you have other family members who participate in the Plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met. Effective for claims incurred on or after March 1, 2018, the out-of-pocket maximums are revised as follows:

<i>Out-of-Pocket Maximum</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$2,000 per person per year (up from \$1,500 per person per year)	\$2,500 per person per year (up from \$2,000 per person per year)
Family Maximum	\$4,000 per family per year (up from \$3,000 per family per year)	\$5,000 per family per year (up from \$4,000 per family per year)

Any member (or family) who satisfies the lower out-of-pocket maximums in effect during the first two months of 2018 during those first two months will be treated as having satisfied the applicable out-of-pocket maximum for the remainder of 2018.

**Prescription Drugs**

We have adopted cost-sharing measures under the Plan's prescription drug benefit. These include requiring the use of generic drugs instead of brand-name drugs when a suitable generic is available, implementing a step therapy program to promote the use of the most cost-effective, therapeutically-appropriate medications, and modifying the Plan's list of approved drugs. All of these changes will be effective on and after March 1, 2018.

- **Generic Drugs** – In most cases when you take a prescription for a brand-name drug to the pharmacy, they will fill your prescription with the generic alternative. Generic medications have the same strength and active ingredients as brand-name drugs, but often cost much less. Starting March 1, 2018, if you ask for the brand-name medication instead of the available generic alternative, you'll pay a higher amount to fill your prescription. This will happen even if your doctor requests the brand-name medication. You will pay the Plan's 50% coinsurance plus the difference in cost between the brand-name and the generic medication.
- **Step Therapy** – The step therapy program that becomes effective March 1, 2018, encourages the use of lower-cost, clinically appropriate medications. These are typically generics or preferred brands. You will be required to try these medications first before the Plan will pay for more expensive brand-name drugs. If you fill a prescription for a step therapy medication, Cigna will send you and your doctor a letter that lets you know the steps you need to take before your next refill.
- **Value Prescription Drug List** – On March 1, 2018, the Plan's list of approved drugs (formulary) will change. The Value Prescription Drug (VPD) list includes more generic and lower-cost brand medications compared to other approved drug lists. The VPD list does not cover certain high-cost brand-name medications that have lower-cost, therapeutically equivalent alternatives. If you fill a prescription for a drug that's listed as a non-preferred brand on the VPD list, you may pay more to fill your prescription. If you're taking a medication that is not on the VPD list, you should talk with your doctor about other medications that may work for you. The Plan will continue to cover *generic* prescription medications to treat allergies (non-sedating antihistamines) and medications used to treat stomach acid conditions, but it will not cover *brand-name* drugs in these categories (like Clarinex, Xyzal, Nexium, and Prilosec). You can check [myCigna.com](http://myCigna.com) to see all of the medications covered under the Plan.

You will receive more information about these prescription drug changes directly from Cigna.

### **Best Doctors Program**

For several years we have made a special "second opinion" program available to you. The Best Doctors Program provides access to over 53,000 medical specialists who have been designated as the best in their field by other doctors. Through Best Doctors, you can have your medical case reviewed by a specialist who provides a detailed report with treatment recommendations, and get answers to questions about a diagnosis or treatment plan. It is an innovative benefit that complements the care you receive from your own doctor.

To use the Best Doctors Program you make a single, confidential call, and Best Doctors does the rest. They collect your information and records over the phone or through the Internet. The service is completely confidential. Information is not shared with your employer or the Fund office, and it's only shared with your treating physician if you authorize it. A Best Doctors specialist will review your situation and provide a detailed report with his or her recommendations, so that you can make an informed treatment decision.

Beginning on March 1, 2018, use of the Best Doctors program will be required for certain non-emergency, elective procedures. If you and your treating physician are thinking about elective surgery on your hip, back, or knee(s), you should call Best Doctors first, at 1-866-904-0910, or visit [members.bestdoctors.com](http://members.bestdoctors.com).

### **COBRA Rates**

The Plan's COBRA rates have changed for the period from March 1, 2018, through February 28, 2019. The rate for Single Coverage will be \$600 per month. The rate for Family Coverage will be \$1,200 per month.

For those who qualify for COBRA disability coverage, the Single rate will be \$900 per month and the Family rate will be \$1,800 per month.

### **Questions**

If you have any questions, please contact Cigna at 800-244-6224 or, if they are unable to answer your questions, please contact the Fund Office at 316-264-2339.

Sincerely,

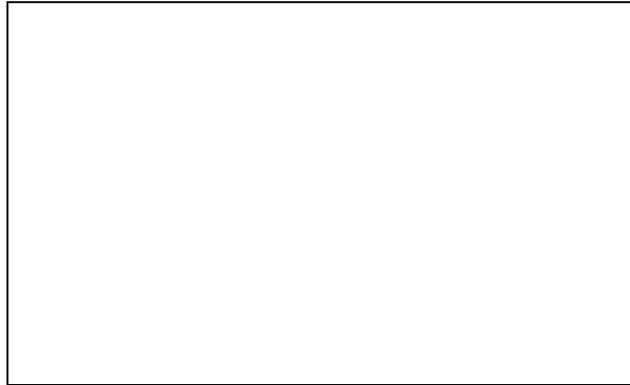
Board of Trustees

*Receipt of this Notice does not constitute a determination of your eligibility for benefits under the Plan. If you wish to verify eligibility, or if you have any questions regarding these Plan changes, please contact the Fund Office. In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of Plan changes.*

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**Group Benefit Plan**



**provided by:**

**Plumbing and Pipefitting Industry  
Health and Welfare Fund  
of Kansas**

**Administered by**

**Plumbing and Pipefitting Industry  
Health and Welfare Fund of Kansas**

**Cigna**

**and**

**Delta Dental of Kansas, Inc.**

**January 1, 2016**

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## **Plumbing and Pipefitting Industry Health and Welfare Plan of Kansas**

January 2016

To Our Members:

This booklet will acquaint you with the benefits offered under the Plumbing and Pipefitting Industry Health and Welfare Plan of Kansas (the “Plan”). Assets used to pay for benefits under the Plan are held in a trust called the Plumbing and Pipefitting Industry Health and Welfare Fund of Kansas, which we sometimes refer to as the “Trust Fund.” These benefits have been designed to give each covered member the most protection that will be consistent with the stability of the Trust Fund itself.

The Trust Fund is a demonstration of cooperation between your Local Union and your employers, to provide you with protection against financial emergencies so often caused by illness and accidents. The successful operation of any group health program, and the assurance that each eligible member will receive benefits, depends to a great extent on the interest and cooperation of each member. Each member should personally see that the requirements of the Plan are observed by all and should cooperate fully in providing reports and information that may be required, thereby protecting the interests of all eligible members.

We are proud of this Plan, and know that you will share in our pride. You should carefully study this booklet and keep it for future reference. If you have any questions, do not hesitate to contact the Plan Administrator at 505 S. Broadway, Suite 117, Wichita, Kansas 67202, Phone (316) 264-2339 or (800) 423-6517.

Very truly yours,

Employer Trustees

Union Trustees

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This booklet is a summary of the benefits provided under the Plan. It is sometimes referred to as a “summary plan description.” It is not the official Plan document. If there is a conflict between the terms of this booklet and the terms of the Plan document, the terms of the Plan document will control. These benefits are funded through the Trust Fund.

The Trust Fund provides three broad categories of benefits: Health Care Benefits, described in Part II of this booklet, Dental Benefits, described in Part III, and Other Welfare Benefits, described in Part IV. Other Welfare Benefits include Death Benefits, Accidental Death and Dismemberment, Disability Benefits, a Retiree Benefit Program, a frozen Retiree Subsidy Program, and Vision Benefits. The Fund Trustees have delegated administrative responsibilities for some of these benefits to the following outside administrators:

- Cigna administers the Health Care Benefits. Claims for Health Care Benefits should be filed with Cigna. Although Health Care Benefits are paid from the Trust Fund, the Trust Fund has entered into a contract with an insurer that provides stop-loss coverage to shield the Trust Fund from unexpectedly high claims expenses.
- Delta Dental of Kansas (“Delta Dental”), a nonprofit dental service corporation, administers the Dental Benefits. Claims for dental benefits should be filed with Delta Dental. Dental Benefits are paid from the Trust Fund, and Delta Dental is not the insurer of these benefits.
- The Trustees of the Trust Fund administer all other benefits under the Plan. Claims for these benefits should be filed with the Plan Administrator.

All benefits are paid out of the Trust Fund. In fact, all benefits ultimately are paid by you and your employer. It is in your best interest to inform the Trustees of any abuse of our Plan by any individual or organization.

You must keep the Plan Administrator informed of your current address at all times. If you move, it is your responsibility to inform the Plan Administrator of your new address.

Please take time to read this booklet now. Don’t wait until there is an emergency. You will feel more secure knowing ahead of time what protection you have against the high cost of illness, and how those expenses will be covered. After reading this booklet, keep it in a place where you can find it for easy reference.

**IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE PLAN ADMINISTRATOR. ONLY THE EMPLOYEES OF THE TRUST FUND ARE AUTHORIZED TO INTERPRET THE PLAN. PLAN INTERPRETATIONS PROVIDED BY EMPLOYERS, LOCAL UNION EMPLOYEES OR INDIVIDUAL PLAN TRUSTEES ARE NOT BINDING ON THE TRUST.**

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**IMPORTANT**

**ALL ADMISSIONS TO HOSPITALS AND MEDICAL CARE FACILITIES FOR INPATIENT CARE REQUIRE PRIOR AUTHORIZATION, OR YOU MAY BE RESPONSIBLE FOR MEDICALLY UNNECESSARY SERVICES.**

**PHYSICIAN PAYMENTS WILL BE BASED ON NORMAL ADMINISTRATIVE PROCEDURES OF THE SERVICING AGENT.**

**ALL CLAIMS PAID ARE A COST OF THE TRUST FUND.**

## TABLE OF CONTENTS

### PART I

<b>General Information and Eligibility Rules .....</b>	<b>1</b>
Eligibility Rules .....	1
Employees .....	1
Initial Eligibility .....	1
Termination of Coverage of Employees and Dependents of Employees.....	1
Contributions for Shareholder Employees .....	2
Dollar Bank .....	3
Maintenance of Eligibility.....	3
Self-Contributions .....	3
Cancellation of Dollar Bank Balances .....	4
Reinstatement of Eligibility .....	4
Dependents .....	5
Maternity Benefits.....	5
Qualified Medical Child Support Orders .....	6
Coverage for Dependents of a Deceased Employee .....	6
Continuation and Reinstatement of Coverage on Account of Qualified Uniformed Service	6
Continuation of Coverage Under the Family and Medical Leave Act.....	9
Continuation of Coverage Under COBRA.....	9
Retiree Benefit Program.....	14
Subsidy for Certain Retired Employees .....	14
Compliance With Claim Rules.....	14
Amendment or Termination of the Plan.....	15
Information About the Plan.....	16
Plan Year and Benefit Period .....	16
Claim for Benefits .....	16
Coordination of Benefits .....	16
One-Year Limitation on Legal Action .....	21
Coordination, Reimbursement, Subrogation and Set-Off .....	21
Bargaining Agreement .....	22
Name of Plan.....	22
Name and Address of Sponsor .....	22
Sponsor IRS Identification and Plan Number .....	22
Type of Administration .....	22
Type of Plan .....	22
Plan Administrator Name and Address.....	22
Legal Process.....	22
Funding Entity.....	23
Termination .....	23
Trustees of the Plan.....	24
Your Rights .....	25
Receive Information About Your Plan and Benefits .....	25

Continue Group Health Plan Coverage .....25  
Prudent Actions by Plan Fiduciaries .....25  
Enforce Your Rights.....25  
Assistance with Your Questions .....26

**PART II**

**Cigna Health Care Benefits.....27**  
Special Plan Provisions .....27  
    Services Available in Conjunction With Your Medical Plan .....27  
    Case Management .....27  
    Additional Programs .....28  
    Care Management and Care Coordination Services .....28  
Important Notices .....29  
    Notice of Grandfathered Plan Status .....29  
How To File Your Claim .....29  
    Claim Reminders .....29  
    Timely Filing of Out-of-Network Claims .....30  
Preferred Provider Medical Benefits.....39  
    Pre-Admission Certification/Continued Stay Review for Hospital Confinement .....39  
    Prior Authorization/Pre-Authorized .....39  
    Covered Expenses .....40  
    Clinical Trials .....43  
    Genetic Testing .....44  
    Nutritional Evaluation .....44  
    Internal Prosthetic/Medical Appliances .....44  
    Orthognathic Surgery .....45  
    Home Health Care Services .....45  
    Hospice Care Services.....45  
    Mental Health and Substance Abuse Services .....46  
    Inpatient Mental Health Services .....47  
    Outpatient Mental Health Services .....47  
    Inpatient Substance Abuse Rehabilitation Services .....47  
    Outpatient Substance Abuse Rehabilitation Services .....48  
    Substance Abuse Detoxification Services .....48  
    Exclusions .....48  
    Durable Medical Equipment .....49  
    External Prosthetic Appliances and Devices.....50  
    Prostheses/Prosthetic Appliances and Devices .....50  
    Orthoses and Orthotic Devices.....50  
    Braces .....51  
    Splints.....51  
    Short-Term Rehabilitative Therapy .....52  
    Chiropractic Care Services.....53  
    Breast Reconstruction and Breast Prostheses.....53  
    Reconstructive Surgery .....53  
    Transplant Services .....53  
    Transplant Travel Services.....54

Prescription Drug Benefits	
For You and Your Dependents .....	56
Covered Expenses .....	56
Limitations .....	56
Your Payments .....	57
Exclusions .....	57
Reimbursement/Filing a Claim .....	58
Exclusions, Expenses Not Covered and General Limitations.....	59
Exclusions and Expenses Not Covered.....	59
General Limitations.....	63
Coordination of Benefits .....	63
Medicare Eligibles .....	63
Expenses For Which A Third Party May Be Responsible.....	64
Subrogation/Right of Reimbursement.....	65
Lien of the Plan .....	65
Additional Terms.....	65
Payment of Benefits .....	66
To Whom Payable.....	66
Recovery of Overpayment .....	67
Calculation of Covered Expenses .....	67
Federal Requirements.....	67
Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks.....	68
Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA) .....	68
Coverage for Maternity Hospital Stay .....	70
Women’s Health and Cancer Rights Act (WHCRA).....	70
Definitions.....	70
Bed and Board.....	70
Charges.....	70
Chiropractic Care .....	70
Custodial Services .....	70
Emergency Services .....	71
Essential Health Benefits .....	71
Expense Incurred.....	71
Free-Standing Surgical Facility.....	71
Fund.....	72
Hospice Care Program .....	72
Hospice Care Services.....	72
Hospice Facility.....	72
Hospital .....	72
Hospital Confinement or Confined in a Hospital.....	73
Injury .....	73
Maintenance Treatment.....	73
Maximum Reimbursable Charge - Medical .....	73
Medicaid.....	73
Medically Necessary/Medical Necessity.....	73

Medicare .....	74
Member .....	74
Necessary Services and Supplies .....	74
Nurse .....	74
Other Health Care Facility/Other Health Professional .....	74
Participating Pharmacy .....	75
Participating Provider .....	75
Patient Protection and Affordable Care Act of 2010 (“PPACA”) .....	75
Pharmacy .....	75
Pharmacy & Therapeutics (P & T) Committee .....	75
Physician .....	75
Prescription Drug .....	75
Prescription Drug List .....	75
Prescription Order .....	76
Preventive Treatment .....	76
Psychologist .....	76
Related Supplies .....	76
Review Organization .....	76
Sickness – For Medical Insurance .....	76
Skilled Nursing Facility .....	76
Specialist .....	77
Terminal Illness .....	77
Urgent Care .....	77

**PART III**

<b>Dental Benefits .....</b>	<b>78</b>
Provision of Dental Coverage .....	78
Your Dental Coverage .....	78
How to Use Your Dental Benefits .....	78
Predetermination of Benefits .....	78
Participating Dentists .....	79
Non-Participating Dentists .....	79
Emergency Treatment .....	80
Inquiries/Complaints .....	80
Regional Consultants .....	81
Appeals to the Trust Fund .....	81
Plan’s Right to Information .....	81
Definitions .....	81
List of Dental Benefits .....	82
Deductible Limitations .....	84
Maximum Benefit Per Person .....	84
Exclusions and Limitations .....	84
Termination of Benefits .....	89
Coordination of Benefits .....	89

**PART IV**

**Schedule of Other Welfare Benefits Provided Directly By The Fund .....90**

Claiming Benefits Provided Directly by the Trust Fund .....90

Death Benefits .....90

Accidental Death and Dismemberment Benefits (AD&D).....90

Schedule of AD&D Benefits.....92

Weekly Disability Benefits .....92

Schedule of Disability Benefits.....93

Retiree Benefit Program.....93

Frozen Retiree Subsidy Program .....94

Vision Benefits.....94

**PART V**

**Claims and Appeals Procedures .....95**

Claims Procedures Chart.....95

Appeals Procedures Chart .....96

Claims and Appeals Procedures.....97

## **PART I**

### **GENERAL INFORMATION AND ELIGIBILITY RULES**

#### **ELIGIBILITY RULES**

##### **Employees**

All employees working for an employer that is required by a collective bargaining agreement to make contributions to the Trust Fund, or for an employer within the geographical jurisdiction of the bargaining agreement establishing and maintaining the Fund, as well as certain employees of the Trust Fund, Local 441 of the United Association of Plumbers and Pipefitters (the "Union"), and the Joint Apprenticeship Committee shall be eligible to receive benefits, after meeting the eligibility requirements described below.

##### **Initial Eligibility**

An employee initially becomes eligible for benefits after having been credited with employer contributions to the Trust Fund in the amount of 450 pro-rated hours, in a qualifying work period of no less than 3 and no more than 12 consecutive months. An employee has a credited hour for each hour he or she performs bargaining unit work for a contributing employer. Eligibility begins the first day of the second month following the end of the applicable 3 to 12 consecutive month period.

Special eligibility rules apply to members of collective bargaining units newly organized by the Union. They will be eligible for coverage on the first day of the first month following a qualifying work period, which may be as short as a single month. A member of such a bargaining unit on the day it was organized will receive an opening balance in his or her Dollar Bank equal to 310 hours multiplied by the current contribution rate. These special rules will only apply if, during at least the 30 days immediately before the effective date of the bargaining agreement that applies to that unit, the employer provided comprehensive medical care to employees in the unit.

The dependent of an employee will be eligible for benefits on the later of the date the employee becomes eligible, or the date a person becomes a dependent.

If an employee acquires a newborn child, the newborn child will automatically be covered for the first 31 days following the child's birth. If a copy of the newborn child's birth certificate is not submitted to the Plan Administrator within the first 31 days following the child's birth, coverage will be extended an additional 60 days to allow time for a birth certificate to be submitted. If the newborn child's birth certificate is not submitted to the Plan Administrator by the end of the 60-day period, the newborn child's coverage will be terminated. If the Plan Administrator receives a birth certificate after the 60-day period has expired and coverage has been terminated, the newborn child's coverage will be reinstated retroactive to the date of termination, but only if the child has incurred any claims.

##### **Termination of Coverage of Employees and Dependents of Employees**

Your coverage under the Plan will terminate at 12:01 a.m. on whichever of the following days occurs first:

1. The first day of the first month in which an employee no longer has sufficient dollars credited to his or her Dollar Bank account to permit the Plan to maintain his or her coverage for that month;
2. The first day immediately following the date you cease to be either an employee or ready, willing and available for work for an employer in a collective bargaining unit represented by the Union;
3. The first day immediately following the date you cease to be a dependent;
4. The date an employee enters the armed forces on active duty;
5. The first day of the fourth calendar month after the calendar month in which the Plan Administrator provides notice to your or, in the case of a dependent, your sponsor's, contributing employer of its failure to comply with the Plan's requirements for posting a bond; or
6. The date the Plan is terminated.

If you leave a bargaining unit represented by the Union to work for an employer who has no obligation to contribute to the Fund (a "noncontributing employer"), you must immediately notify the Plan Administrator of this change in your employment status. Effective as of the date of such a change in employment status, your coverage under this Plan, and the coverage of your dependents, will terminate. While you are employed by such a noncontributing employer you may not use the Dollar Bank or make self-payments to continue your coverage under the Plan. This is because neither the Dollar Bank nor the self-payment privilege is intended to provide what would, in effect, be a subsidy to a noncontributing employer.

If you fail to notify the Plan Administrator that you are working for a noncontributing employer and thereby continue your coverage under the Plan, you will be deemed to have committed fraud. Consequently, the Plan Administrator may rescind your coverage and the coverage of your dependents effective as of the date on which it otherwise would have terminated.

Other provisions of the Plan describe how you may be able to keep your coverage, even though it might otherwise terminate under this Section. For example, if you are a dependent of a deceased employee, you may obtain coverage after the employee's death through the Dollar Bank provisions of the Plan. You may also be eligible to continue your coverage under COBRA or on account of Qualified Uniformed Service.

### **Contributions for Shareholder Employees**

If you own stock in your employer, you will not be eligible to participate in the Plan unless your employer makes contributions on your behalf for a minimum of 40 hours per week. Coverage for you will end as of the first day of the month immediately following the month in which such a contribution is due but not timely made. In the event that you leave covered employment, you will not be eligible to participate again in the Plan until at least 24 months have elapsed since your departure.

### **Dollar Bank**

The Plan maintains bookkeeping accounts called the “Dollar Bank.” It allows the Plan to keep a record of the contributions made by employers for their employees, and by employees on their own behalf. Each month, the Plan credits the Dollar Bank with dollars for each employee in an amount equivalent to the amount of employer contributions made on behalf of each employee and the amount of contributions made by employees who meet the self-contribution requirements described below. No actual accounts or deposits are maintained by the Dollar Bank, but a record of the number of dollars accumulated by each employee is kept by the Plan. This account shall not accumulate credit of more than the product of 12 times the Minimum Eligibility Amount, plus one. The “Minimum Eligibility Amount” is a dollar amount equal to 140 multiplied by the current contribution rate.

### **Maintenance of Eligibility**

Once you become eligible, the Minimum Eligibility Amount will be taken from the Dollar Bank each month to maintain your eligibility. An employee will remain eligible for each month in which there is a balance in his or her Dollar Bank, but only if, throughout the previous month:

1. He or she was working in a bargaining unit represented by the Union;
2. He or she was seeking such work;
3. He or she was totally disabled; or
4. He or she had some combination of these.

An employee will be able to maintain coverage, for example, if he or she had been working in a bargaining unit represented by the Union for part of the month and had been seeking such work for the rest of the month. For purposes of this Section, an employee will be regarded as totally disabled during any period in which, as a result of illness or injury, he or she is unable to perform bargaining unit work and is not performing any other work for wage or profit.

### **Self-Contributions**

Self-contributions are allowed from employees who are in danger of losing eligibility due to unemployment. These contributions are made in the amount of the difference between employer contributions received and the Minimum Eligibility Amount for each month that an employee has a “partial month’s” balance in the Dollar Bank. Employee dollars thus contributed will be credited to the employee’s account in the same way as employer dollars. Self-contribution payments must be received or postmarked within 10 days of the date Cigna or the Plan sends a notice describing your ability to maintain coverage by self-paying (as directed by the Plan Administrator) to the employee’s last address on record. If a self-contribution is not received by Cigna, the member will lose his or her eligibility. (If you choose not to self-contribute or if no contributions were made by your employer on your behalf, you may be eligible for COBRA Continuation Coverage.) Eligibility can only be re-established by employer contributions. Self-contributions can only be made for a month in which an employee has a balance of “employer contributions” in the Dollar Bank (only the month(s) for which you owe a “partial payment”). If an employee elects to continue coverage pursuant to the COBRA rights described in the Section of this booklet titled “**Continuation of Coverage Under COBRA,**” and returns to covered

employment prior to the expiration of this coverage, the employee will not be required to re-qualify. (For more information about COBRA, refer to the Section of this booklet labeled **“Continuation of Coverage under COBRA.”**)

### **Cancellation of Dollar Bank Balances**

The balance in an employee’s Dollar Bank will be cancelled as of the last day of the 12<sup>th</sup> consecutive calendar month following the last day he worked in a bargaining unit represented by the Union, or was ready, willing and available for work for an employer in a collective bargaining unit represented by the Union.

### **Reinstatement of Eligibility**

An employee who fails to remain eligible for benefits under the Plan will become eligible again on the first day of the second calendar month following 3 to 12 consecutive months during which he or she is credited with contributions in the amount of 450 pro-rated hours.

Any employee who becomes ineligible due to Qualified Uniformed Service, as defined in the Section of this booklet titled **“Continuation and Reinstatement of Coverage on Account of Qualified Uniformed Service,”** and who has accumulated a portion of the hours necessary to establish a qualifying work period or has accumulated any Dollar Bank dollars, shall have such hours or dollars restored if he or she applies for or returns to a position of employment with an employer who has an obligation to contribute to the Plan on his or her behalf, but only if he or she has reemployment rights protected by applicable federal law regarding uniformed service.

Consistent with the special election described in paragraph 3 of the Section of this booklet titled **“Continuation and Reinstatement of Coverage on Account of Qualified Uniformed Service,”** an employee who elects to continue his or her coverage under the Plan during a period of Qualified Uniformed Service may also elect to waive restoration of any Dollar Bank balance he or she had at the beginning of the Qualified Uniformed Service, and instead use that balance to qualify for continued coverage during the period of Qualified Uniformed Service until the balance is exhausted. After that, so long as his or her Qualified Uniformed Service continues, its cost shall be governed by the self-payment provisions in paragraph 2 of the Section of this booklet titled **“Continuation and Reinstatement of Coverage on Account of Qualified Uniformed Service.”** On his or her reemployment after the Qualified Uniformed Service ends, such an employee shall have coverage under the Plan until he or she again has sufficient hours credited to his or her Dollar Bank account to permit the Plan to maintain his or her coverage for a given month, but only if each of the following requirements is met:

1. He or she applies for or returns to a position of employment with an employer who has an obligation to contribute to the Plan on his or her behalf, but only if he or she has reemployment rights protected by applicable federal law regarding uniformed service; and
2. He or she pays for such coverage as if it were COBRA continuation coverage, subject to the rules on the cost and duration of COBRA continuation coverage and the timing of payments set forth in the Section of this booklet titled **“Continuation of Coverage Under COBRA.”**

## **Dependents**

An employee's spouse and eligible children may be eligible for coverage as dependents. A **spouse** means a person to whom an employee is legally married as determined under the Internal Revenue Code. Common-law spouses are not eligible for coverage.

An **eligible child** is any person:

1. Who is the natural or adopted child of an employee;
2. Who:
  - (a) has not reached the end of the month in which his or her 26<sup>th</sup> birthday occurs; or
  - (b) is a disabled child.

A **disabled child** means any child who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. Upon submission of an application by an employee, the Plan Administrator will determine the eligibility of a person to receive coverage as a disabled child. The Plan Administrator shall require, as sole proof of disability, the determination by the Social Security Administration that the child is entitled to disability benefits under the federal Social Security Act. The Plan Administrator may require that proof of disability be submitted from time to time after the initial determination of disability.

The Plan provides coverage for **adopted children** only when the child is adopted or placed for adoption, and only if the adoption or placement occurs before the child reaches his or her 18th birthday. A child will be considered placed for adoption when an employee assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption.

In addition, under federal law, a **qualified medical child support order** may require a child of an employee to be covered under this Plan even if the child is not an eligible child.

You must notify the Plan Administrator immediately in writing of a divorce, or if a dependent ceases to be an eligible dependent for any other reason. If you fail to provide the Plan Administrator with a written notification, and the Plan pays a benefit to, or on behalf of, an ineligible dependent, the Trust Fund may hold you responsible for the incorrect payments.

## **Maternity Benefits**

The Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to less than 48 hours, or to less than 96 hours in the case of a cesarean section. In addition, the Plan will not require a provider to obtain authorization or precertification from Cigna or its designee for prescribing any length of stay described above. However, these rules shall not apply where the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay periods described above is made by the mother's or child's attending provider in consultation with the mother.

### **Qualified Medical Child Support Orders**

The Plan will honor qualified medical child support orders. A medical support order, typically issued in divorce proceedings, may create or recognize the right of a child of an employee to be covered under the Plan. The medical child support order must be issued by a court of competent jurisdiction and be “qualified.” You may contact the Plan Administrator for a copy of the guidelines the Plan uses to determine whether a medical child support order is qualified. You must provide the Plan Administrator a copy of any medical child support order. Until you do so, the Plan may withhold benefits or may hold you responsible for the incorrect payments.

### **Coverage for Dependents of a Deceased Employee**

After the death of an employee, the dependents of the employee who were receiving coverage under the Plan on the date of the employee’s death may continue coverage with the dollars remaining in the deceased employee’s Dollar Bank. The Plan will debit the Minimum Eligibility Amount from the deceased employee’s Dollar Bank to maintain coverage for dependents in each month after the employee’s death. Dependents will be entitled to the Plan’s Health Care Benefits, Vision Benefits, and Dental Benefits. The level of coverage will be the same as that provided under the Plan. Because only employees are eligible for the Plan’s Death Benefits, Accidental Death and Dismemberment Benefits, and Weekly Disability Benefits, dependents are not entitled to receive coverage for those benefits.

Dependents will remain eligible for coverage as long as the deceased employee’s Dollar Bank has a balance of at least the Minimum Eligibility Amount. Coverage will terminate on the first day of the first month in which there are no longer sufficient dollars in the deceased employee’s Dollar Bank to permit the Plan to maintain coverage for that month. Once the Dollar Bank’s balance is under the Minimum Eligibility Amount, the dependents may be eligible for COBRA coverage.

Notwithstanding any of the foregoing, any spouse who remarries while receiving coverage purchased with dollars remaining in the deceased employee’s Dollar Bank shall lose any right to continue receiving such coverage. Coverage will terminate on the first day of the month in which such spouse remarries.

### **Continuation and Reinstatement of Coverage on Account of Qualified Uniformed Service**

Apart from the rights to continued Plan coverage described elsewhere in this booklet, you may be entitled to continue certain aspects of your Plan coverage during a period of Qualified Uniformed Service. You also may have certain reinstatement rights following a period of Qualified Uniformed Service. The specific rules are as follows:

1. Persons Eligible for Continued Coverage. An employee who is absent from the employment of his or her employer on account of a period of Qualified Uniformed Service may elect to continue employee and dependent medical coverage on a self-pay basis or by making the special election provided in paragraph 3 of this Section, for the 24 month period beginning on the date on which the employee is first absent from employment by reason of Qualified Uniformed Service. Coverage will terminate on the earlier of the day after the date on which the employee fails to apply for or return to a position of employment, if the failure to apply or return terminates the employee’s right to reemployment rights under applicable federal law regarding uniformed service, or

when the grace period for making payments that are due, as described in paragraph 6 of this Section, expires.

2. Cost of Continued Coverage. The monthly charge for continued coverage will be determined by the Trustees, and will be the same for all similarly situated individuals electing the same type of coverage under this provision. If any single period of Qualified Uniformed Service is for a period of less than 31 days, the only amount required to be paid by the employee is the amount, if any, the employee would pay if he or she had not entered Qualified Uniformed Service. In other cases, the employee's charge will reflect both the employee's portion and the employer's portion, determined in the same manner as COBRA charges.
3. Election to Use Dollar Bank Balance. All or part of the monthly charge described in paragraph 2 of this Section may be avoided by the employee's election to use the balance in his or her Dollar Bank account to qualify for continuing coverage during his or her Qualified Uniformed Service until that balance is exhausted. See paragraph 7 of this Section.
4. Benefits Subject to Continuation. Any election made by an employee applies to the employee and the employee's dependents who otherwise would lose coverage under the Plan. No separate election may be made by any dependent. The medical coverage that employees are allowed to continue on behalf of themselves and their dependents will be the same as that provided to active employees and their dependents under the Plan. Except in connection with circumstances that permit other employees to make changes, an employee may continue only the type of coverage that he or she was receiving on the day before the employee first was absent from employment.
5. Election of Continued Coverage. An employee eligible to continue coverage under this provision will be sent an application for continued coverage within 30 days after the Plan Administrator receives notice, satisfactory to the Plan Administrator, that the employee will be, or is, absent from employment for a period of Qualified Uniformed Service. If an employee wishes to have coverage continued, he or she must complete the application and return it to the Plan Administrator within 60 days from the later of the date the application is sent or the date coverage otherwise would terminate.
6. Payment for Continued Coverage. The continuation of coverage is conditioned on an employee's payment of the monthly charges for the coverage, determined from the date coverage otherwise would terminate, even if the employee waits 60 days from that date to return the application. If an employee elects continued coverage, payment must be made, relating back to the date that coverage otherwise would terminate, within 45 days after the date the employee elects to continue coverage. After that, payments must be made by the first day of each month for which coverage is to be provided, subject to a 30-day grace period.
7. Reinstatement of Coverage. Special protections apply if, immediately following a period of Qualified Uniformed Service, an individual resumes service with a contributing employer and, during Qualified Uniformed Service, coverage under the Plan was

terminated. In that case, and notwithstanding other Sections of this booklet, exclusions and waiting periods will be applied to the individual and his or her dependents only to the extent they would have applied if coverage had not been terminated as a result of Qualified Military Service. Exclusions and waiting periods will be applied, nonetheless, in the case of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The Section of this booklet titled **“Reinstatement of Eligibility”** contains additional rules regarding reinstatement rights.

8. Life Insurance, Accidental Death and Dismemberment, and Disability Benefits. These special rules for Qualified Uniformed Service apply to Health Care Benefits, Vision Benefits and Dental Benefits only. For purposes of applying the provisions of the Plan, and of any applicable insurance policy, regarding the Plan’s Life Insurance Benefit, Accidental Death and Dismemberment Benefit, and Weekly Disability Benefit, the rights and benefits of an employee who is absent from employment on account of a period of Qualified Uniformed Service shall be equivalent to those of an employee having similar seniority, status and pay who is on furlough or leave of absence for the period of Qualified Uniformed Service.
9. Qualified Uniformed Service. An absence from employment shall be considered “Qualified Uniformed Service” only if the following conditions are satisfied:
  - (a) The service constitutes the performance of duty on a voluntary or involuntary basis under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard Duty, and a period for which an employee is absent from employment for the purpose of an examination to determine the fitness of the employee to perform any such duty.
  - (b) The service is in one of the “uniformed services.” “Uniformed services” means the Armed Forces of the United States, the Army National Guard and the Air National Guard when engaged in active duty for training or inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.
  - (c) The employee had coverage under this Plan at the time his or her service began.
  - (d) The period of service does not exceed 60 months or such other period as may be required by applicable law.
10. Election by Family Members, Other Personal Representatives. When the Plan Administrator determines that it is appropriate under the circumstances, any election required to be made by an employee under this Section while the employee is engaged in a period of Qualified Uniformed Service may be made by one of the employee’s family members or a personal representative. Any such election shall be binding on the employee and any dependents to whom it pertains.

11. Construction. The Plan's provisions on military service shall be construed and applied to be consistent with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994.

### **Continuation of Coverage Under the Family and Medical Leave Act**

If your employer grants you a leave of absence under the Family and Medical Leave Act, contributions made on your behalf will be accounted for in the same manner as contributions made on behalf of actively working employees.

### **Continuation of Coverage Under COBRA**

Apart from the rights to continued Plan coverage described in the preceding Sections, you may be entitled to continue certain aspects of your Plan coverage as provided in this Section. It contains important information about your right to COBRA coverage, which is a temporary extension of coverage under the Plan. This Section also contains information about other coverage alternatives that may be available to you through the Health Insurance Marketplace.

The right to COBRA coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA coverage can become available to you and to other members of your family who are covered under the Plan when you or they would otherwise lose coverage. This Section generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

1. Qualified Beneficiaries. The Plan offers COBRA coverage to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Specific qualifying events are listed below. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA coverage must pay for it. An individual is also eligible to elect COBRA coverage if:
  - (a) He or she is a child born to, adopted by, or placed for adoption with an employee or former employee while the employee or former employee is receiving COBRA coverage; or
  - (b) His or her coverage under the Plan is reduced or eliminated in anticipation of a qualifying event.

In the case of subparagraph (a), above, so long as newborn or newly adopted children elect COBRA coverage within 60 days of their birth or adoption, they will enjoy an independent right to maintain their COBRA coverage in the event that the employee or

former employee drops his or her own COBRA coverage before the end of the maximum coverage continuation period.

In the case of subparagraph (b), above, a person whose coverage under the Plan is reduced or eliminated in anticipation of a qualifying event becomes eligible to elect COBRA coverage upon the occurrence of the qualifying event.

An individual is not eligible to elect COBRA coverage if, on the day before the qualifying event, the individual is covered under the Plan by reason of another person's election of COBRA coverage, and the individual is not otherwise eligible under these provisions. If multiple individuals are eligible to elect COBRA coverage due to the same qualifying event, each individual has a separate right to elect such coverage.

2. COBRA Qualifying Events. COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event."

An *employee* will become a qualified beneficiary if he or she would lose coverage under the Plan because either of the following qualifying events occurs:

- (a) The termination of the employee's employment; or
- (b) A reduction in the employee's work hours below the minimum needed to maintain his or his dependents' eligibility under the Plan.

A *dependent spouse* of an employee will become a qualified beneficiary if he or she would lose coverage under the Plan because any of the following qualifying events occur:

- (a) The death of the employee;
- (b) The termination of the employee's employment;
- (c) A reduction in the employee's work hours below the minimum needed to maintain his or his dependents' eligibility under the Plan; or
- (d) The divorce of the employee.

A *dependent child* of an employee will become a qualified beneficiary if he or she would lose coverage under the Plan because any of the following qualifying events occur:

- (a) The death of the employee;
- (b) The termination of the employee's employment;
- (c) A reduction in the employee's work hours below the minimum needed to maintain his or her dependents' eligibility under the Plan;
- (d) The divorce of the employee; or
- (e) The child's ceasing to qualify as an "eligible child" under the Plan.

If an employee fails to return to work after a leave of absence under the Family and Medical Leave Act, the qualifying event occurs on the last day of the leave of absence.

3. Coverage Continuation Periods. If an employee and his or her dependents would lose coverage because of his or her termination of employment or reduction in work hours, the employee and his or her dependents may apply for continuation of either “Medical” coverage or “Full” Plan coverage for up to 18 months after coverage would otherwise be lost. A special rule applies if an employee becomes entitled to Medicare within 18 months prior to the loss of coverage as a result of termination of employment or reduction in work hours. In such a case, the employee’s loss of coverage will entitle his dependents to continuation coverage that extends until the later of (a) 18 months after coverage would otherwise be lost, or (b) 36 months after the employee’s Medicare entitlement. If the employee’s dependents would lose coverage as a result of the employee’s death, divorce or a child’s ceasing to be an “eligible child” under the Plan, those dependents may apply for continuation of coverage for up to 36 months.
  
4. Successive Qualifying Events. If an employee’s dependents elect continued coverage following the employee’s termination of employment or reduction in work hours, and then a second qualifying event that would otherwise entitle the employee’s dependents to 36 months of continued coverage occurs during that continuation period, those dependents may elect to continue their coverage for up to 36 months, rather than only 18 months. This 36-month period will be determined by adding an additional 18 months to the original 18-month period. Should this situation arise, dependents will be given another opportunity to elect or decline continued coverage for the remainder of the 36-month period. In order to be eligible for extended coverage under this paragraph, an individual must be eligible to elect COBRA coverage under the provisions described above at the time of the second qualifying event. A qualified beneficiary (or his or her representative) must notify the Plan Administrator within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator, at the address shown in the Section of this booklet titled **“Information About the Plan.”**

In no case will any cumulative period of continuation coverage extend beyond 36 months.

5. Social Security Disability. A special rule applies if an employee or his or her dependent is determined to have been disabled. The disability has to have started at some time before the 60th day of COBRA coverage attributable to an employee’s termination of employment or reduction in hours and must last at least until the end of the 18-month period of continuation coverage. Subject to the conditions described in this and the following paragraph, such a disabled individual (and all other members of that individual’s family who are receiving continuation coverage due to the same qualifying event) may purchase up to 11 more months of coverage — for a total of 29 months. The cost of such coverage may be higher, however, during these last 11 months than during the initial 18 months. The determination of disability must be made by the Social Security Administration, and must be issued within the disabled individual’s initial 18 months of continuation coverage. One of the persons eligible for this extension must then notify the Plan Administrator of the Social Security Administration’s disability

determination within 60 days after the later of (a) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event, or (b) the date the disability determination is issued (and within the individual's first 18 months of continuation coverage.) This notice must be sent to the Plan Administrator.

If the Social Security Administration later determines that an individual described in the preceding paragraph is no longer disabled, that individual must notify the Plan Administrator within 30 days after the date of that second determination. This notice must be sent to the Plan Administrator. The individual's right to the 11-month extension of continuation coverage will terminate as of the first day of the month that begins more than 30 days after the second determination is issued.

6. Coverage of Newborn and Newly Adopted Children. A child born to, adopted by, or placed for adoption with a former employee while the former employee is receiving COBRA coverage will be allowed to enroll in COBRA coverage as well. Thus, so long as proper notice of the birth or adoption is provided to the Plan Administrator, a former employee will be allowed to add any newborn or newly adopted child to that individual's COBRA coverage immediately upon the child's birth or adoption.
7. Notification Requirements. It will be the obligation of the employee, former employee or dependent to notify the Plan Administrator within 60 days of any divorce, child's birth, adoption or placement for adoption, or a child's ceasing to be an "eligible child" under the terms of the Plan. This notice must be sent to the Plan Administrator at the Plan Administrator's address, which is set forth in the Section of this booklet titled "**Information About the Plan.**" If such timely notice is not received, continuation coverage will not be available with respect to that event.
8. Cost of COBRA Continuation Coverage. The monthly charge for continued coverage will be determined by the Trustees, and will be the same for all similarly situated individuals electing the same type of coverage under this provision. In their discretion, however, the Trustees may require smaller monthly payments by former employees who are actively seeking work in a bargaining unit represented by the Union than by other former employees.
9. Benefits Subject to Continuation. The coverage that employees and their dependents are entitled to continue will be the same as that provided to employees and their dependents under the Plan. If an employee or his dependents choose to continue coverage under this Section, that individual or individuals will be entitled to the Plan's Health Care Benefits, Death Benefits, Accidental Death and Dismemberment Benefits, Weekly Disability Benefits, Vision Benefits, and Dental Benefits. Because only employees are eligible for the Plan's Death Benefits, Accidental Death and Dismemberment Benefits, and Weekly Disability Benefits, dependents are not entitled to continue any of those benefits.
10. Election of COBRA Coverage. An individual eligible to continue his or her coverage under COBRA will be sent an application for continued coverage within 30 days after the Plan Administrator is notified of a qualifying event. If that individual wishes to continue

his or her coverage, he or she must complete the application and return it within 60 days from the later of the date it is sent to the individual or the date his or her coverage would otherwise terminate.

11. Payment for COBRA Coverage. If an individual elects continued coverage under COBRA, he or she must make payment for the period from the date coverage would otherwise terminate. If the individual waits 60 days to respond, he or she would still have to make payment from the coverage termination date. Payment for this pre-election period must be made within 45 days after the individual elects to continue coverage. For the period after his or her election date, payments must be made by the first day of each month for which coverage is provided — subject to a 30-day grace period.

If an individual makes payment for continued coverage under COBRA of an amount that is less than the amount due for that month's premium but greater than ninety percent (90%) of the amount of the premium due, the Plan Administrator will notify the individual of the deficiency. To maintain coverage, the individual must pay that deficiency within 30 days of the date the Plan Administrator notifies the individual of it.

12. Termination of COBRA Coverage. Continued coverage under COBRA for an employee or dependent is subject to automatic termination prior to the end of the maximum coverage period upon the occurrence of any of the following events:

- (a) If a required payment is not made before the end of the 30-day grace period described above; or
- (b) If, after an individual elects continued coverage, he or she becomes covered under another employer group health plan (as an employee or otherwise); or
- (c) If, after an individual elects continued coverage, he or she becomes entitled to Medicare benefits; or
- (d) If the last employer to contribute to the Plan on behalf of the individual ceases to be required to contribute to the Plan and either:
  - (i) makes group health plan coverage available to a class of its employees formerly covered under the Plan; or
  - (ii) starts to contribute to another multiemployer plan that is a group health plan with respect to a class of its employees formerly covered under the Plan.

For purposes of this rule:

- the last employer to contribute on behalf of a retiree is the last employer to have employed the retiree and to have been obligated to make contributions on his behalf; and

- the last employer to contribute on behalf of a dependent is the last employer to have employed, and to have been obligated to make contributions on behalf of, the employee whose participation in the Plan permitted the dependent to be covered; or
- (e) If coverage has been extended for up to 29 months due to disability and there is a final determination that the individual is no longer disabled.

If an employee selects COBRA continuation coverage and returns to covered employment prior to the expiration of this coverage, the employee will not be required to requalify for eligibility.

13. Other Coverage Options. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### **Retiree Benefit Program**

Retirees and their spouses from age 60 to 65 may elect to continue coverage under the Plan's Retiree Benefit Program, but only if they are covered by the Plan at the time they attain age 60. Participants in the Retiree Benefit Program will be entitled to the same benefits as actively working employees, including the Plan's Health Care Benefits, Vision Benefit, Dental Benefits, Life Insurance Benefit, and Accidental Death and Dismemberment Benefit. The level of coverage will be the same as that provided under the Plan. However, participants in the Retiree Benefit Program shall not be entitled to the Plan's Weekly Disability Benefit. See the detailed description of the "**Retiree Benefit Program**" in Part IV of this booklet.

### **Subsidy for Certain Retired Employees**

Prior to January 1, 2010, the Plan provided a subsidy to cover part of the cost of individual insurance policies for certain retirees (and their spouses) from age 60 until age 65 (the "Retiree Subsidy Program"). All retirees (and their spouses) who were participating in the Retiree Subsidy Program were given the opportunity to elect between continuing to participate in the Retiree Subsidy Program or participating instead in the Retiree Benefit Program. See the detailed description of the "**Frozen Retiree Subsidy Program**" in Part IV of this booklet.

### **Compliance With Claim Rules**

In order to obtain benefits, all claimants must comply with the applicable claim rules set forth and established under the Plan. The Trustees shall exercise every right provided to them under those rules to prevent any claimant from receiving benefits who is, in their opinion, attempting to subvert the purposes of the Trust, or who does not present a bona fide claim.

In some instances, the Plan Administrator will request supporting documentation from you, such as birth certificates, marriage licenses, domestic relations orders or medical child support orders. The Plan may withhold benefits until such documents are received.

**Amendment or Termination of the Plan**

As is true of other benefits described in this booklet, the Trustees may at any time amend, terminate, or change the benefits provided under the Plan or their cost for employees, retirees and their dependents.

## INFORMATION ABOUT THE PLAN

### **Plan Year and Benefit Period**

The year end date which is used for purposes of maintaining the Plan's fiscal records is July 31. The Plan's Benefit Period is January 1 through December 31.

### **Claim for Benefits**

Claims for benefits may be filed on forms available at the Plan Administrator's office. You must file your initial claim for benefits with the appropriate benefit administrator.

1. Submitting a Claim for Health Care Benefits. For Health Care Benefits (including Health Care Benefits provided under the Retiree Benefit Program), claims must be submitted to Cigna. In most cases, the doctor, hospital, or other health care provider which furnishes services to you will file a claim on your behalf with Cigna. If the provider elects not to file a claim on your behalf, or if you receive services from a provider who has not entered into a contracting provider agreement with Cigna, you should obtain an itemized statement from the provider, complete the Medical or Prescription Drug Claim Form, as applicable, available from the Plan Administrator or Cigna, and send the completed Claim Form and itemized statement to:

Medical Claims

Cigna Healthcare  
P.O. Box 182223  
Chattanooga, TN 37422-7223

Prescription Drug Claims

Cigna Pharmacy Service Center  
P.O. Box 188053  
Chattanooga, TN 37422-8053

2. Submitting a Claim for Benefits Provided Directly from the Trust Fund. The Trust Fund provides several benefits directly, rather than through an insurance company or Cigna. These benefits include Vision, Weekly Disability, Death, and Accidental Death and Dismemberment benefits. In addition, the Frozen Retiree Subsidy described in Part IV of this booklet is paid, if at all, directly from the Fund. Claims for any of these benefits should be submitted directly to the Plan Administrator on forms available from the Administrator's office.
3. Submitting a Claim for Dental Benefits. The Dental Benefits are administered by Delta Dental. Any claims filed for dental benefits should be addressed to:

Delta Dental of Kansas, Inc.  
P.O. Box 49198  
Wichita, Kansas, 67201-9198

### **Coordination of Benefits**

This Section applies if you or any one of your dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

1. Definitions. For the purposes of this Section, the following terms have the meanings set forth below:

- (a) **Plan** means any of the following that provides benefits or services for medical or dental care or treatment. However, if separate benefit descriptions are used to provide coordinated coverage for subscribers of a group, the separate benefit descriptions are considered parts of the same Plan and there is no coordination of benefits among those separate benefit descriptions.
- “Plan” includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans, or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
  - “Plan” does not include: hospital indemnity coverage or other fixed indemnity coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

- (b) **Closed Panel Plan** means a Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.
- (c) **Primary Plan** means a Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.
- (d) **Secondary Plan** means a Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.
- (e) **Allowable Expense** means a necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
  - If you are confined to a private hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
  - If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
  - If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
  - If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.
- (f) **Claim Determination Period** means a calendar year, but does not include any part of a year during which you are not covered under this Plan or any date before this Section or any similar provision takes effect.
- (g) **Reasonable Cash Value** means an amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.
- (h) **Custodial Parent** means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
2. **Order of Benefit Determination Rules.** A Plan that does not have a coordination of benefits rule consistent with this Section shall always be the Primary Plan. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

If the Plan does have a coordination of benefits rule consistent with this Section, the first of the following rules that applies to the situation is the one to use:

- (a) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.
- (b) Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Plan is:
- (i) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
- The parents are married;
  - The parents are not separated (whether or not they ever have been married); or
  - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If both parents have the same birthday, the Plan that covered either of the parents longer is primary.
- (ii) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.
- (iii) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
- The Plan of the Custodial Parent;
  - The Plan of the spouse of the Custodial Parent;
  - The Plan of the noncustodial parent; and then
  - The Plan of the spouse of the noncustodial parent.

- (c) Active or Inactive Employee. The Plan that covers a person as an employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under subparagraph 2(a), above.
- (d) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (e) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is primary.
- (f) If the preceding rules do not determine the Primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this Section. In addition, this Plan will not pay more than it would have paid had it been primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above will be used to determine how benefits will be coordinated.

- 3. Effect on the Benefits of This Plan. If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan; coordination of benefits shall not apply between that Plan and other Closed Panel Plans.

- 4. Recovery of Excess Benefits. If the Plan pays charges for benefits that should have been paid by the Primary Plan, or if the Plan pays charges in excess of those for which it is obligated to provide under the Plan, the Plan will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

The Plan will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

5. **Right to Receive and Release Information.** This Plan, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this Section. You must provide us with any information we request in order to coordinate your benefits pursuant to this Section. This request may occur in connection with a submitted claim; if so, you will be advised that the “other coverage” information, (including an explanation of benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

**One-Year Limitation on Legal Action**

You or your representative may not bring any lawsuit against the Plan, Trust Fund, Trustees, or a representative or fiduciary of the Plan or Trust Fund, more than one year from the later of: (i) the date your claim is first filed, or (ii) the date the Plan renders a decision on your claim or, if you timely file an appeal with the Plan, on your appeal.

**Coordination, Reimbursement, Subrogation and Set-Off**

The Plan is designed to help you reduce the costs of injury and illness. It is not intended to provide you with benefits greater than your medical expenses.

By implementing various rules, some of which are described further in other provisions of this booklet, the Plan seeks to avoid the duplication of benefits payable by another plan or person in order to minimize the cost of providing health care. Where appropriate, and as examples of options available to the Plan, it may:

- Coordinate the benefits payable under this Plan with benefits payable under any other plan or by any other person, so that the total amount paid will not exceed your medical expenses;
- Seek reimbursement of excess payments from you, your parent or spouse if you are a dependent, any other plan or person which has received payment, or any other plan or person which should have made payment;
- Proceed to collect any claim you may have against any other plan or person for the injury or illness which occasioned the payment of benefits under this Plan; and
- Set off all or part of the amount it has not recovered against any amounts otherwise payable to you or on your behalf or to any person in your family or on his or her behalf.

Example:

Mark Young is an employee and is injured in an automobile accident. This Plan will take into account benefits payable under his automobile insurance policy as well as any benefits payable under the automobile insurance policy of anyone who may be liable for his injuries. And if this Plan chooses, it may bring suit directly against anyone who may be liable for his injuries. If this Plan pays his medical expenses and then he becomes entitled to receive compensation for his

injuries from an insurance company, this Plan will demand that the insurance company first pay the Plan up to the amount of benefits the Plan paid for treatment of those injuries. If the insurance company does not reimburse the Plan, and Mark then receives compensation for his injuries from the insurance company, he must reimburse the Plan for the benefits the Plan paid for treatment of those injuries.

**Bargaining Agreement**

The Plan is maintained in accordance with collective bargaining agreements between contributing employers or their representatives and the United Association of Plumbers and Pipefitters Local 441.

Copies of the agreements may be obtained upon written request to the Plan Administrator and may be examined in the Plan Administrator's office. Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer contributes to the Plan and, if so, the employer's address.

**Name of Plan**

Plumbing and Pipefitting Industry Health and Welfare Plan of Kansas

**Name and Address of Sponsor**

Board of Trustees of the  
Plumbing and Pipefitting Industry  
Health and Welfare Fund of Kansas  
505 S. Broadway, Suite 117  
Wichita, Kansas 67202-3922  
800-423-6517 or 316-264-2339

ONLINE [www.PPI-FUND.ORG](http://www.PPI-FUND.ORG)

**Sponsor IRS Identification and Plan Number**

EIN: 48-6127146  
PN: 501

**Type of Administration**

Trustee Administration

**Type of Plan**

Health, Prescription Drug, Dental, Vision, Death, and Disability

**Plan Administrator Name and Address**

Joe D. Pucci, Administrator for the Trustees  
505 S. Broadway, Suite 117  
Wichita, Kansas 67202-3922  
800-423-6517 or 316-264-2339

**Legal Process**

The name and street address of the person who is designated as the legal agent for receiving service of legal process for the Plan is:

Joe D. Pucci, Administrator for the Trustees  
505 S. Broadway, Suite 117  
Wichita, Kansas 67202-3922

Service of legal process may also be made upon a Plan Trustee.

**Funding Entity**

The Plan is funded principally through employer contributions that are made to the Plumbing and Pipefitting Industry Health and Welfare Trust Fund of Kansas, although in some cases, employee contributions may be made as well.

The contributions to be made by employers are determined by the terms of the applicable collective bargaining agreements. All other contributions are determined by the Board of Trustees. The contributions, together with earnings on them, are held in trust until they are disbursed to pay benefits or other expenses of the Plan. The custodian which holds such assets is currently Emprise Bank, 257 N. Broadway, Wichita, Kansas 67201-2970.

**Amendment or Termination**

The Trustees have the power to terminate the Plan with the unanimous consent of the Union and employers that were parties to the Trust Agreement, but in any event the Plan will terminate when there is no longer in force a bargaining agreement requiring contributions. The Trustees may amend the Plan from time to time in any manner they in their sole discretion deem appropriate. Where the Plan provides benefits pursuant to an insurance policy, the insurer will construe the terms of the policy and must consent to any amendment affecting benefits provided under the policy.

**Interpretation**

The Trustees have the power to construe the terms of the Plan and to determine all questions that arise under it, including but not limited to questions concerning eligibility for and the nature and extent of, benefits it provides.

## TRUSTEES OF THE PLAN

The names and addresses of the Trustees under the Plan are:

### **Employer Trustees**

Mr. Neil Carlson  
Plumbing By Carlson, Inc.  
1820 SW Van Buren  
Topeka, KS 66612

Mr. Melvin J. Copeland  
P1 Group, Inc.  
2721 SE Scorpio Ave.  
Topeka, KS 66605-1833

Mr. John G. Feeback  
Vice President  
Feeback and Associates  
12321 Augusta Dr.  
Kansas City, KS 66109-3167

Mr. Gregory S. Johnson  
Vice President  
Mechanical Systems Inc.  
P.O. Box 3029  
Wichita, KS 67201-3029

Mr. Ronald D. Sturgeon  
President  
Sturgeon Plumbing & Air  
Conditioning Inc.  
P.O. Box 1769  
Hutchinson, KS 67504-1769

### **Employee Trustees**

Mr. Phillip R. Petty  
Agent/Organizer  
Plumbers & Pipefitters  
Local Union 441  
P.O. Box 1417  
Manhattan, KS 66505-1417

Mr. Rick Salyer  
Agent/Organizer  
Plumbers & Pipefitters  
Local Union 441  
7038 SW 17<sup>th</sup> St.  
Topeka, KS 66615-1140

Mr. Richard L. Taylor  
Business Manager  
Plumbers & Pipefitters  
Local Union 441  
1330 E. 1st St., Ste. 115  
Wichita, KS 67214-4000

Mr. Bill J. Urton  
Agent/Dispatcher  
Plumbers & Pipefitters  
Local Union 441  
1330 E. 1st St., Ste. 115  
Wichita, KS 67214-4000

Mr. Mike Wolownik  
Agent/Organizer  
Plumbers & Pipefitters  
Local Union 441  
103 Mendicki Road  
Frontenac, KS 66763-8107

## **YOUR RIGHTS**

As a participant in the Plumbing and Pipefitting Industry Health and Welfare Plan of Kansas you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

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

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

### **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 people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit

in a federal court. (Refer to Section 22 of Part V for a statement of the requirement that you may not bring a lawsuit against the Plan unless you fully pursue your right to appeal, as explained in Part V.) If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210-0002. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## **PART II**

### **CIGNA HEALTH CARE BENEFITS**

Benefits described in Part II of this booklet are administered by Cigna. All claims for health care benefits should be filed with Cigna. Any questions you have regarding these benefits should be addressed to Cigna.

You will find terms starting with capital letters throughout this Part II. To help you understand your benefits, most of these terms are defined in the Definitions Section of this Part II.

The Schedule is a brief outline of the maximum benefits which may be payable under your coverage. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

### **SPECIAL PLAN PROVISIONS**

When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your dependents appropriate care while lowering medical costs.

#### **Services Available in Conjunction With Your Health Care Benefits**

The following pages describe helpful services available in conjunction with your health care benefits. You can access these services by calling the toll-free number shown on the back of your ID card.

#### **Case Management**

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate

treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, a claim office or a utilization review program (see the PAC/CSR Section of this Part II) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the Plan, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

### **Additional Programs**

Cigna may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to Members for the purpose of promoting their general health and wellbeing. Cigna may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Fund. Contact us for details regarding any such arrangements.

### **Care Management and Care Coordination Services**

Cigna may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing

participants with certain care management and care coordination services to facilitate achievement of these goals.

## **IMPORTANT NOTICES**

### **Notice of Grandfathered Plan Status**

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the phone number or address provided in Part I of this booklet. An explanation also can be found on Cigna’s website at [http://www.Cigna.com/sites/healthcare\\_reform/customer.html](http://www.Cigna.com/sites/healthcare_reform/customer.html).

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

## **HOW TO FILE YOUR CLAIM**

There’s no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

### **Claim Reminders**

- Be sure to use your Member ID and account/group number when you file Cigna’s claim forms, or when you call your Cigna claim office.

Your Member ID is the ID shown on your benefit identification card.

Your account/group number is shown on your benefit identification card.

- Be sure to follow the instructions listed on the back of the claim form carefully when submitting a claim to Cigna.

### **Timely Filing of Out-of-Network Claims**

Cigna will consider claims for coverage when proof of loss (a claim) is submitted within 455 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 455 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

**WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

<b>Preferred Provider Medical Benefits The Schedule</b>
<b>For You and Your Dependents</b>
<p>Preferred Provider Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Preferred Provider Medical Benefits, you and your dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Coinsurance.</p> <p>When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level.</p> <p>If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this Plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.</p>
<b>Coinsurance</b>
<p>The term Coinsurance means the percentage of charges for Covered Expenses that a covered person is required to pay under the Plan.</p>
<b>Out-of-Pocket Expenses</b>
<p>Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the Plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the Plan at 100%:</p> <ul style="list-style-type: none"><li>• Coinsurance.</li></ul> <p>The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the Plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:</p> <ul style="list-style-type: none"><li>• Non-compliance penalties.</li><li>• Provider charges in excess of the Maximum Reimbursable Charge.</li></ul>
<b>Accumulation of Plan Out-of-Pocket Maximums</b>
<p>Out-of-Pocket Maximums do not cross-accumulate (that is, In-Network will accumulate to In-Network and Out-of-Network will accumulate to Out-of-Network). All other Plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.</p>

<b>Preferred Provider Medical Benefits The Schedule</b>		
<p><b>Multiple Surgical Reduction</b></p> <p>Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.</p>		
<p><b>Assistant Surgeon and Co-Surgeon Charges</b></p> <p><b>Assistant Surgeon</b></p> <p>The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon’s allowable charge as specified in Cigna reimbursement policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance amounts.)</p> <p><b>Co-Surgeon</b></p> <p>The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna reimbursement policies.</p>		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Lifetime Maximum</b>	Unlimited	
<p>The Percentage of Covered Expenses the Plan Pays</p> <p><b>Note:</b> “No charge” means a covered person is not required to pay Coinsurance.</p>	50%	30% of the Maximum Reimbursable Charge
<p><b>Maximum Reimbursable Charge</b></p> <p>Maximum Reimbursable Charge is determined based on the lesser of the provider’s normal charge for a similar service or supply; or</p> <p>A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected.</p> <p><b>Note:</b> The provider may bill you for the difference between the provider’s normal charge and the Maximum Reimbursable Charge, in addition to applicable coinsurance.</p> <p><b>Note:</b> Some providers forgive or waive the cost share obligation (e.g. your coinsurance) that this Plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this Plan. For more details, see the Exclusions Section.</p>	Not Applicable	80th Percentile

Preferred Provider Medical Benefits The Schedule		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Out-of-Pocket Maximum</b></p> <p>Individual Family Maximum</p> <p><b>Individual Calculation:</b> Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.</p>	<p>\$1,500 per person \$3,000 per family</p>	<p>\$2,000 per person \$4,000 per family</p>
<p><b>Combined Medical/Pharmacy Out-of-Pocket Maximum</b></p> <p>Combined Medical/Pharmacy Out-of-Pocket: includes prescription drugs</p>	<p>Yes</p>	<p>Yes</p>
<p><b>Physician's Services</b></p> <p>Primary Care Physician's Office Visit Specialty Care Physician's Office Visits Consultant and Referral Physician's Services <b>Note:</b> OB/GYN provider is considered a Specialist. Surgery Performed in the Physician's Office Second Opinion Consultations (provided on a voluntary basis) Allergy Treatment/Injections Allergy Serum (dispensed by the Physician in the office)</p>	<p>50% 50% 50% 50% 50% 50%</p>	<p>30% 30% 30% 30% 30%</p>
<p><b>Preventive Care</b></p> <p><b>Note:</b> Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. Routine Preventive Care <b>Note:</b> Well-woman OB/GYN visits will be considered a Specialist visit.</p>		
<p>Physician's Office Visit Immunizations <b>Note:</b> Flu shots are covered at 100%</p>	<p>50% 50%</p>	<p>30% 30%</p>

Preferred Provider Medical Benefits The Schedule		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Mammograms, PSA, PAP Smear</b> Preventive Care Related Services (i.e. "routine" services) Diagnostic Related Services (i.e. "non-routine" services)	50%  Subject to the Plan's x-ray & lab benefit; based on place of service	30%  Subject to the Plan's x-ray & lab benefit; based on place of service
<b>Inpatient Hospital - Facility Services</b> Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)	50% Limited to the semi-private room negotiated rate Limited to the semi-private room negotiated rate Limited to the negotiated rate	30% Limited to the semi-private room rate Limited to the semi-private room rate Limited to the ICU/CCU daily room rate
<b>Outpatient Facility Services</b> Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	50%	30%
<b>Inpatient Hospital Physician's Visits/Consultations</b>	50%	30%
<b>Inpatient Hospital Professional Services</b> Surgeon Radiologist Pathologist Anesthesiologist	50%	30%
<b>Outpatient Professional Services</b> Surgeon Radiologist Pathologist Anesthesiologist	50%	30%

Preferred Provider Medical Benefits The Schedule		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Emergency and Urgent Care Services</b>		
Physician's Office Visit	50%	50%
Hospital Emergency Room	50%	50%
Outpatient Professional Services (radiology, pathology and ER Physician)	50%	50%
Urgent Care Facility or Outpatient Facility	50%	50%
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	50%	50%
Independent x-ray and/or Lab Facility in conjunction with an ER visit	50%	50%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	50%	50%
Ambulance	50%	50%
<b>Inpatient Services at Other Health Care Facilities</b>	50%	30%
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities		
Calendar Year Maximum: Unlimited		
<b>Laboratory and Radiology Services (includes pre-admission testing)</b>		
Physician's Office Visit	50%	30%
Outpatient Hospital Facility	50%	30%
Independent X-ray and/or Lab Facility	50%	30%
<b>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</b>		
Physician's Office Visit	50%	30%
Inpatient Facility	50%	30%
Outpatient Facility	50%	30%

<b>Preferred Provider Medical Benefits The Schedule</b>		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Outpatient Short-Term Rehabilitative Therapy</b></p> <p>Calendar Year Maximum: Unlimited</p> <p>Includes: Cardiac Rehab Physical Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy</p>	50%	30%
<p><b>Speech Therapy</b></p> <p>Calendar Year Maximum: 90 days</p>	50%	30%
<p><b>Chiropractic Care</b></p> <p>Calendar Year Maximum: Unlimited</p> <p>Calendar Maximum Amount: \$800 maximum per family</p> <p>Physician's Office Visit</p>	50%	30%
<p><b>Home Health Care</b></p> <p>Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)</p>	50%	30%
<p><b>Hospice</b></p> <p>Inpatient Services</p> <p>Outpatient Services (same coinsurance level as Home Health Care)</p>	50%	30%
<p><b>Bereavement Counseling</b></p> <p>Services provided as part of Hospice Care</p> <p>Inpatient</p> <p>Outpatient</p> <p>Services provided by Mental Health Professional</p>	50%	30%
	Covered under Mental Health Benefit	Covered under Mental Health Benefit

Preferred Provider Medical Benefits The Schedule		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Maternity Care Services</b>		
Initial Visit to Confirm Pregnancy <b>Note:</b> OB/GYN provider is considered a Specialist.	50%	30%
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	50%	30%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	50%	30%
Delivery - Facility (Inpatient Hospital, Birthing Center)	50%	30%
<b>Abortion</b>		
Includes elective and non-elective procedures		
Physician's Office Visit	50%	30%
Inpatient Facility	50%	30%
Outpatient Facility	50%	30%
Physician's Services	50%	30%
<b>Family Planning Services</b>		
Office Visits, Lab and Radiology Tests and Counseling <b>Note:</b> The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs)). Diaphragms will also be covered when services are provided in the physician's office.	50%	30%
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)		
Physician's Office Visit	50%	30%
Inpatient Facility	50%	30%
Outpatient Facility	50%	30%
Physician's Services	50%	30%

Preferred Provider Medical Benefits The Schedule		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Infertility Treatment</b></p> <p>Services Not Covered include:</p> <ul style="list-style-type: none"> <li>• Testing performed specifically to determine the cause of infertility.</li> <li>• Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</li> <li>• Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc.).</li> </ul> <p><b>Note:</b> Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.</p>	Not Covered	Not Covered
<p><b>Organ Transplants</b></p> <p>Includes all medically appropriate, non-experimental transplants</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Physician's Services</p> <p>Lifetime Travel Maximum: \$10,000 per transplant</p>	<p>50%</p> <p>50%</p> <p>50%</p> <p>No charge (only available when using Lifesource facility)</p>	<p>30%</p> <p>30%</p> <p>30%</p> <p>In-Network coverage only</p>
<p><b>Durable Medical Equipment</b></p> <p>Calendar Year Maximum: Unlimited</p>	50%	30%
<p><b>External Prosthetic Appliances</b></p> <p>Calendar Year Maximum: Unlimited</p>	50%	30%
<p><b>Routine Foot Disorders</b></p> <p>Calendar Year Maximum: Unlimited</p> <p>Physician's Office Visit</p>	50%	30%

<b>Preferred Provider Medical Benefits The Schedule</b>		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Hearing Aids</b> <b>Note: Coverage for Bone Anchored Hearing aids only</b>	50%	30%
<b>Nutritional Evaluation</b> Calendar Year Maximum: 3 visits per person  Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	   50% 50% 50% 50%	   30% 30% 30% 30%
<b>Dental Care</b> Limited to charges made for oral surgery or for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.  Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	   50% 50% 50% 50%	   30% 30% 30% 30%
<b>Treatment Resulting From Life Threatening Emergencies</b> Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
<b>Mental Health</b>  Inpatient Outpatient (Includes Individual, Group and Intensive Outpatient) Physician's Office Visit Outpatient Facility	  50%  50% 50%	  30%  30% 30%
<b>Substance Abuse</b>  Inpatient Outpatient (Includes Individual and Intensive Outpatient) Physician's Office Visit Outpatient Facility	  50%  50% 50%	  30%  30% 30%

## **PREFERRED PROVIDER MEDICAL BENEFITS**

### **Certification Requirements - Out-of-Network**

#### **For You and Your Dependents**

##### **Pre-Admission Certification/Continued Stay Review for Hospital Confinement**

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your dependent require treatment in a Hospital:

- as a registered bed patient, except for 48/96 hour maternity stays;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for Mental Health or Substance Abuse Residential Treatment Services.

You or your dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred for which benefits would otherwise be payable under this Plan for the charges listed below will not include:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this Plan, except for the coordination of benefits and subrogation provisions explained in the General Information Section of this Plan booklet.

##### **Prior Authorization/Pre-Authorized**

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this Plan.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- non-emergency ambulance; or
- transplant services.

### **Covered Expenses**

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he or she becomes covered for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. **Any applicable Copayments or limits are shown in The Schedule.**

### **Covered Expenses**

- Charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- Charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- Charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- Charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- Charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- Charges made for Emergency Services and Urgent Care.
- Charges made by a Physician or a Psychologist for professional services.
- Charges made by a Nurse, other than a member of your family or your dependent's family, for professional nursing service.

- Charges made for anesthetics and their administration, including general anesthesia and facility charges for dental care provided to the following covered persons:
  - (1) a child five years of age or under;
  - (2) a person who is severely disabled;
  - (3) a person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided; or
  - (4) a person who has anxiety (the claim must be submitted with an anxiety diagnosis).
- Charges made for diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- Charges made for diagnosis and treatment of: corns, calluses, weak or flat feet; any fallen arches, chronic foot strain or instability or imbalance of the feet; toenails (other than removal of nail matrix or root, or services furnished in connection with treatment of metabolic or peripheral vascular disease or of a neurological condition).
- Charges made for an annual prostate-specific antigen test (PSA).
- Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- Charges made for family planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- Charges made for the following preventive care services (detailed information is available at [www.healthcare.gov](http://www.healthcare.gov)):
  - (1) evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;
  - (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the covered person involved;
  - (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

- (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Charges made for surgical or nonsurgical treatment of Temporomandibular Joint Dysfunction.
  - Charges made for Bone Anchored Hearing Aids (BAHAs).
  - Charges made for oral surgery and services for accidental injury to sound natural teeth, but limited to the following:
    - (1) surgical procedures of the jaws and gums;
    - (2) removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
    - (3) removal of exostoses (bony growths) of the jaw and hard palate;
    - (4) treatment of fractures and dislocations of the jaw and facial bones;
    - (5) surgical removal of impacted teeth;
    - (6) treatment (including replacement) for damage to or loss of sound natural teeth caused by an accidental injury;
    - (7) intra-oral dental imaging services in connection with covered oral surgery if treatment begins within 30 days;
    - (8) general anesthesia;
    - (9) cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants, and the associated fixed and/or removable prosthetic appliance when provided because of an accidental injury; or
    - (10) cylindrical endosseous dental implants, mandibular staple implants, subperiosteal implants, and the associated fixed and/or removable prosthetic appliance following surgical resection of either benign or malignant lesions (but not including inflammatory lesions).

Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

### **Clinical Trials**

This Plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

- (a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and
- (b) either
  - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
  - the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this Plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and

- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

### **Genetic Testing**

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

### **Nutritional Evaluation**

Subject to the limitations set forth in The Schedule, charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

### **Internal Prosthetic/Medical Appliances**

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

### **Orthognathic Surgery**

Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:

- the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
- the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
- the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

### **Home Health Care Services**

Charges made for Home Health Care Services when you:

- require skilled care;
- are unable to obtain the required care as an ambulatory outpatient; and
- do not require confinement in a Hospital or Other Health Care Facility.

Home Health Care Services are provided under the terms of a Home Health Care plan for the person named in that plan.

If you are a minor or an adult who is dependent upon others for nonskilled care (e.g. bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your nonskilled care needs.

**Home Health Care Services** are those skilled health care services that can be provided during intermittent visits of two hours or less by Other Health Care Professionals. Necessary consumable medical supplies, home infusion therapy, and Durable Medical Equipment administered or used by Other Health Care Professionals in providing Home Health Care Services are covered. Home Health Care Services do not include services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-Term Rehabilitative Therapy."

### **Hospice Care Services**

Charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:

- by a Hospice Facility for Bed and Board and Services and Supplies;

- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for:
  - part-time or intermittent nursing care by or under the supervision of a Nurse;
  - part-time or intermittent services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the Plan if the person had remained or been Confined in a Hospital or Hospice Facility.

**The following charges for Hospice Care Services are not included as Covered Expenses:**

- for the services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house;
- for any period when you or your dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the Plan;
- for services or supplies that are primarily to aid you or your dependent in daily living.

**Mental Health and Substance Abuse Services**

**Mental Health Services** are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

**Substance Abuse** is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

### **Inpatient Mental Health Services**

Services that are provided by a Hospital while you or your dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

### **Outpatient Mental Health Services**

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

**Partial Hospitalization** sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

### **Inpatient Substance Abuse Rehabilitation Services**

Services provided for rehabilitation, while you or your dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Residential Treatment services.

**Substance Abuse Residential Treatment Services** are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

**Substance Abuse Residential Treatment Center** means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

### **Outpatient Substance Abuse Rehabilitation Services**

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program and for Partial Hospitalization sessions.

**Partial Hospitalization** sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

### **Substance Abuse Detoxification Services**

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

### **Exclusions**

The following are specifically excluded from Mental Health and Substance Abuse Services:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement;
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders;
- counseling for activities of an educational nature;
- counseling for borderline intellectual functioning;

- counseling for occupational problems;
- counseling related to consciousness raising;
- vocational or religious counseling;
- I.Q. testing;
- custodial care, including but not limited to geriatric day care;
- psychological testing on children requested by or for a school system; and
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

### **Durable Medical Equipment**

Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

### **Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:**

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.

- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

### **External Prosthetic Appliances and Devices**

Charges made or ordered by a Physician for the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

### **Prostheses/Prosthetic Appliances and Devices**

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

### **Orthoses and Orthotic Devices**

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses;
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.

- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

**The following are specifically excluded orthoses and orthotic devices:**

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

**Braces**

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

**The following braces are specifically excluded: Copes scoliosis braces.**

**Splints**

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.

- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older;
- no more than once every 12 months for persons 18 years of age and under; and
- replacement due to a surgical alteration or revision of the site.

**The following are specifically excluded external prosthetic appliances and devices:**

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

#### **Short-Term Rehabilitative Therapy**

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

**Short-term Rehabilitative Therapy services that are not covered include but are not limited to:**

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

Multiple outpatient services provided on the same day constitute one day.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

### **Chiropractic Care Services**

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

The following limitation applies to Chiropractic Care Services:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

### **Chiropractic Care services that are not covered include but are not limited to:**

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- vitamin therapy.

### **Breast Reconstruction and Breast Prostheses**

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

### **Reconstructive Surgery**

Charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician. Breast reduction surgery is not covered even when deemed to be medically necessary.

### **Transplant Services**

Charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are covered at the Out-of-Network level.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation (refer to Transplant Travel Services), hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

### **Transplant Travel Services**

Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation and lodging are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and lodging while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age. The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income; travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered

subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available when the covered person is a donor.

<b>Prescription Drug Benefits The Schedule</b>		
<b>For You and Your Dependents</b>		
This Plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Copayment and/or Coinsurance.		
<b>Coinsurance</b> The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your dependent are required to pay under this Plan.		
<b>Charges</b> The term Charges means the amount charged by the Insurance Company to the Plan when the Pharmacy is a Participating Pharmacy, and it means the actual billed charges when the Pharmacy is a non-Participating Pharmacy.		
BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
<b>Lifetime Maximum</b>	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
<b>Out-of-Pocket Maximum</b> Individual  Family	Refer to the Medical Benefits Schedule  Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule  Refer to the Medical Benefits Schedule
<b>Retail Prescription Drugs</b>	<b>The amount you pay for each 34-day supply (or 100-day supply of a maintenance medication)</b>	<b>The amount you pay for each 34-day supply (or 100-day supply of a maintenance medication)</b>
<b>Tier 1</b> Generic* drugs on the Prescription Drug List	50%	50%
<b>Tier 2</b> Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	50%	50%
<b>Tier 3</b> Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	50%	50%
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

## **PRESCRIPTION DRUG BENEFITS FOR YOU AND YOUR DEPENDENTS**

### **Covered Expenses**

If you or any one of your dependents, while covered for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in The Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

### **Limitations**

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 34-day supply (or 100-day supply of a maintenance medication), at a retail Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Cigna to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Plan, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P&T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

### **Your Payments**

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule, after you have satisfied your Prescription Drug Coinsurance, if applicable. Please refer to the Schedule for any required Copayments, Coinsurance, or Maximums if applicable.

In no event will the Copayment or Coinsurance for the Prescription Drug or Related Supply exceed the amount paid by the Plan to the Pharmacy, or the Pharmacy's Usual and Customary (U&C) charge. Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers regardless of the customer's payment source.

### **Exclusions**

No payment will be made for the following expenses:

- Drugs available over the counter that do not require a prescription by federal or state law unless state or federal law requires coverage of such drugs;
- Any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- A drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- Injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in the standard reference compendia (AHFS or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in peer-reviewed English-language bio-medical journals;
- Prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;

- Implantable contraceptive products;
- Any fertility drug;
- Drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasm, and decreased libido;
- Prescription vitamins (other than prenatal vitamins), dietary supplements unless state or federal law requires coverage of such drugs;
- Diet pills or appetite suppressants (anorectics);
- Prescription smoking cessation products;
- Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- Replacement of Prescription Drugs and Related Supplies due to loss or theft;
- Drugs used to enhance athletic performance;
- Drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- Prescriptions more than one year from the original date of issue;
- Any drugs that are experimental or investigational as described under the Medical “Exclusions” section of this Part II.

Other limitations are shown in the Medical “Exclusions” Section of this Part II.

### **Reimbursement/Filing a Claim**

When you or your dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment or Coinsurance shown in the Schedule at the time of purchase. You do not need to file a claim form.

If you or your dependents purchase your Prescription Drugs or Related Supplies through a non-Participating Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

See your Fund’s Plan Administrator to obtain the appropriate claim form.

## **EXCLUSIONS, EXPENSES NOT COVERED AND GENERAL LIMITATIONS**

### **Exclusions and Expenses Not Covered**

**Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this Plan:**

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this Plan. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your Plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section(s) of this Plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” section(s) of this Plan.
- 
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
  - The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
  - Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with oral surgery and accidental injury to sound natural teeth are covered as set forth in the “Covered Expenses” section of this Part II. Additional dental services are covered under the Dental Benefits described in Part III of this booklet.
  - For medical and surgical services intended primarily for the treatment or control of obesity. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass.
  - Unless otherwise covered in this Plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
  - Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this Plan.
  - Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote

intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.

- Reversal of male or female voluntary sterilization procedures.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a dependent, unless this infant child is otherwise eligible under this Plan.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or intellectual disabilities.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this Plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this Plan.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants; except as provided in the “Covered Expenses” section of this Part II.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this Plan as a retiree, or their dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.

- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations, and telemedicine.
- Massage therapy.

### **General Limitations**

No payment will be made for expenses incurred for you or any one of your dependents:

- For charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- To the extent that you or any one of your dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- For charges which would not have been made if the person had no insurance.
- To the extent that they are more than Maximum Reimbursable Charges.
- To the extent of the exclusions imposed by any certification requirement shown in this Plan.
- Expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- Charges made by any covered provider who is a member of your or your dependent's family.
- Expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care while temporarily traveling abroad.

### **COORDINATION OF BENEFITS**

All Cigna benefits will be subject to the coordination of benefits and subrogation provisions explained in the General Information Section in Part I of this Plan booklet.

### **MEDICARE ELIGIBLES**

Cigna will pay as the Secondary Plan as permitted by the Social Security Act of 1965, as amended, for the following:

- (a) a former employee who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;
- (b) a former employee's dependent, or a former dependent spouse, who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;
- (c) an employee whose employer and each other employer participating in the Plan have fewer than 100 employees and that employee is eligible for Medicare due to disability;
- (d) the dependent of an employee whose employer and each other employer participating in the Plan have fewer than 100 employees and that dependent is eligible for Medicare due to disability;
- (e) an employee or a dependent of an employee of an employer who has fewer than 20 employees, if that person is eligible for Medicare due to age; and
- (f) an employee, retired employee, employee's dependent, or retired employee's dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

Cigna will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him or her.

This reduction will not apply to any employee and his or her dependent or any former employee and his or her dependent unless he or she is listed under (a) through (f) above.

#### **EXPENSES FOR WHICH A THIRD PARTY MAY BE RESPONSIBLE**

This Plan does not cover:

- Expenses incurred by you or your dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.

- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

### **Subrogation/Right of Reimbursement**

If a Participant incurs a Covered Expense for which, in the opinion of the Plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- **Subrogation:** The Plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the Plan. A Participant or his/her representative shall execute such documents as may be required to secure the Plan's subrogation rights.
- **Right of Reimbursement:** The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted above, but only to the extent of the benefits provided by the Plan.

Please refer to the coordination, reimbursement, subrogation, and set-off provisions explained in the General Information Section in Part I of the Plan booklet for more information.

### **Lien of the Plan**

By accepting benefits under this Plan, a Participant:

- grants a lien and assigns to the Plan an amount equal to the benefits paid under the Plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant, whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the Plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the Plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the Plan.

### **Additional Terms**

- No adult Participant hereunder may assign any rights that he or she may have to recover medical expenses from any third party or other person or entity to any minor dependent of said adult Participant without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.

- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.
- The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The Plan hereby disavows all equitable defenses in pursuit of its right of recovery. The Plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor his or her obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his or her reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this Plan shall not be applicable to this provision because the Plan is governed by ERISA. By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the Plan in pursuing any subrogation or recovery rights by providing requested information.

## **PAYMENT OF BENEFITS**

### **To Whom Payable**

Medical Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid

because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your dependents, you or your dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him or her, such payment will be made to his or her legal guardian. If no request for payment has been made by the legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his or her custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our covered participant and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna and the Plan from all liability to the extent of any payment made.

### **Recovery of Overpayment**

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this Plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment on behalf of the Plan. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

### **Calculation of Covered Expenses**

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the current procedural terminology,
- the methodologies as reported by generally recognized professionals or publications.

## **FEDERAL REQUIREMENTS**

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

### **Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks**

A separate listing of Participating Providers who participate in the network is available to you without charge by visiting [www.cigna.com](http://www.cigna.com); [mycigna.com](http://mycigna.com) or by calling the toll-free telephone number on your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with Cigna HealthCare.

### **Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)**

If you or your eligible dependent(s) experience a special enrollment event as described below, you or your eligible dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible dependent(s) under a different option offered by the Plan for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible dependent(s). You and all of your eligible dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new dependent.** If you acquire a new dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for yourself and your dependents. Enrollment of dependent children is limited to the newborn or adopted children or children who became dependent children of the employee due to marriage.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of dependent status (such as reaching the limiting age);
  - death of the employee;
  - termination of employment;

- reduction in work hours to below the minimum required for eligibility;
  - you or your dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the employee's or dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible dependent(s).
  - **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
  - **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

**Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.**

### **Coverage for Maternity Hospital Stay**

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the “Newborns’ and Mothers’ Health Protection Act”: restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your dependents.

### **Women’s Health and Cancer Rights Act (WHCRA)**

Do you know that your Plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

## **DEFINITIONS**

### **Bed and Board**

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

### **Charges**

The term “charges” means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.

### **Chiropractic Care**

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

### **Custodial Services**

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person’s current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;

- Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self-administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

### **Emergency Services**

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

### **Essential Health Benefits**

Essential health benefits means, to the extent covered under the Plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

### **Expense Incurred**

An expense is incurred when the service or the supply for which it is incurred is provided.

### **Free-Standing Surgical Facility**

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;

- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

### **Fund**

The term Fund means the Plumbing and Pipefitting Industry Health and Welfare Fund of Kansas. The Fund self-insures the benefits described in this booklet, on whose behalf Cigna is providing claim administration services. The term Employer means an employer participating in the Fund.

### **Hospice Care Program**

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

### **Hospice Care Services**

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

### **Hospice Facility**

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

### **Hospital**

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or

- an institution which: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

### **Hospital Confinement or Confined in a Hospital**

A person will be considered Confined in a Hospital if he or she is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

### **Injury**

The term Injury means an accidental bodily injury.

### **Maintenance Treatment**

The term Maintenance Treatment means treatment rendered to keep or maintain the patient's current status.

### **Maximum Reimbursable Charge - Medical**

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- a policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

### **Medicaid**

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

### **Medically Necessary/Medical Necessity**

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;

- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

**Medicare**

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

**Member**

The term Member means a member in good standing of the PLUMBING AND PIPEFITTING INDUSTRY HEALTH AND WELFARE PLAN OF KANSAS.

**Necessary Services and Supplies**

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

**Nurse**

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation “R.N.,” “L.P.N.” or “L.V.N.”

**Other Health Care Facility/Other Health Professional**

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses, licensed practical nurses, dental hygienists, and doctors of dental surgery (DDS). Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

**Participating Pharmacy**

The term Participating Pharmacy means a retail Pharmacy with which Cigna has contracted to provide prescription services to insureds.

**Participating Provider**

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

**Patient Protection and Affordable Care Act of 2010 (“PPACA”)**

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

**Pharmacy**

The term Pharmacy means a retail Pharmacy.

**Pharmacy & Therapeutics (P & T) Committee**

A committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

**Physician**

The term Physician means a licensed medical practitioner who is practicing within the scope of his or her license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality of the Plan if he or she is:

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

**Prescription Drug**

Prescription Drug means; a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

**Prescription Drug List**

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

### **Prescription Order**

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

### **Preventive Treatment**

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

### **Psychologist**

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality of the Plan if he or she is operating within the scope of his or her license and performing a service for which benefits are provided under this Plan when performed by a Psychologist.

### **Related Supplies**

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

### **Review Organization**

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

### **Sickness – For Medical Insurance**

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

### **Skilled Nursing Facility**

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

**Specialist**

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

**Terminal Illness**

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

**Urgent Care**

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the covered person should not travel due to any medical condition.

## **PART III**

### **DENTAL BENEFITS**

The Plan's Dental Benefits described in Part III of this booklet are administered by Delta Dental of Kansas, Inc. Any claims filed for dental benefits or any questions you have regarding these benefits should be addressed to Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, Kansas, 67278-9769. Or, you can visit Delta Dental at 1010 N. Main St., Wichita, Kansas 67203-3615. The telephone number is 800-234-3375 or (316) 264-4511. You may also access the Delta Dental network nationwide, through its website at [www.deltadentalks.com](http://www.deltadentalks.com).

#### **Provision of Dental Coverage**

Your dental benefits are provided by the Trust Fund. The Trust Fund has retained Delta Dental of Kansas, Inc., a nonprofit dental service corporation incorporated under the laws of Kansas ("Delta Dental"), to administer these benefits, including claims processing.

#### **Your Dental Coverage**

Your dental benefits include only the cost of dental procedures necessary to eliminate oral disease or for appliances or restorations required to replace missing teeth, and then only if identified as a covered dental benefit in the List of Dental Benefits that follows. Certain restrictions may apply to your coverage. It is important to review the Dental Exclusions and Limitations Section that appears later in this Part III of the booklet for these conditions.

If any state or federal legislation or regulation is in effect, enacted, or amended mandating a change in the Dental Benefits described in Part III of this booklet, appropriate modifications will be made.

#### **How to Use Your Dental Benefits**

There are no pre-examination requirements for you or your dependents to be eligible for dental benefits.

When you make an appointment with your Dentist, tell the Dentist that you are covered by Delta Dental of Kansas.

#### **Predetermination of Benefits**

In certain cases, you will have to have your dental care pre-approved. If your planned treatment involves any of the following procedures, your Dentist should submit a treatment plan to Delta Dental to determine how much of the bill will be paid by Delta Dental and what your share of the cost will be:

- Prosthodontic or orthodontic procedures;
- Individual crowns (except stainless steel);
- Gold restorations;
- Surgical periodontics;

- Endodontics; or
- Oral surgery (except for simple extraction of a single tooth).

If your Dentist fails to predetermine benefits, you may have to pay more for your treatment than you anticipated, if, in the professional judgment of Delta Dental's consultant, the treatment is not necessary or a lesser procedure could have restored the tooth to contour and function. Even if your Dentist does predetermine benefits, however, Delta Dental is not obligated if you as an employee or dependent are no longer eligible for benefits or your Dentist is not a Participating Dentist at the time the services are actually performed. The treatment must commence within 90 days of the date the treatment plan is submitted to Delta Dental by the treating Dentist or a new treatment plan should be obtained and resubmitted to Delta Dental.

### **Participating Dentists**

Before treatment is started, be sure to discuss with your Dentist the total amount of the bill and the portion, if any, you will be required to pay. You are free to go to the Dentist of your choice; however, there may be a difference in the amount of payment that will be made by Delta Dental if the Dentist you choose is not a Participating Dentist with Delta Dental at the time services are performed.

Following treatment, the attending Dentist's statement should be forwarded by the Dentist to Delta Dental. Delta Dental will make direct payment to the Dentist, if he or she is a Participating Dentist, on each covered procedure, in the amount of the Maximum Plan Allowance for Participating Dentists.

In the case of Participating Dentists, the term "Maximum Plan Allowance" or "MPA" means the lesser of (1) the fee submitted by the Participating Dentist for the dental procedure, (2) the fee that such Participating Dentist has filed with Delta Dental for the dental procedure, if any, or (3) the Delta Participating Dentist Maximum Fee. Any amounts withheld from a Participating Dentist by Delta Dental for reserves, research or other purposes shall be deemed to have been paid as part of the claim of the Participating Dentist. You will receive notice of Delta Dental's payment and of the amount, if any, that you owe the Dentist. The amount you owe should be paid in accordance with the Dentist's usual billing procedure.

A list of Participating Dentists is available to you online at [www.deltadentalks.com](http://www.deltadentalks.com). You may also obtain a copy of the list, without charge, by contacting Delta Dental.

### **Non-Participating Dentists**

For dental benefits and services provided by a Non-Participating Dentist, Delta Dental will pay to you on each covered procedure the applicable co-percentage of the Maximum Plan Allowance for Non-Participating Dentists.

In the case of Non-Participating Dentists, the "Maximum Plan Allowance" or "MPA" means the lesser of (1) the fee submitted by the Non-Participating Dentists for the dental procedure, or (2) the Delta Non-Participating Dentists Maximum Fee.

### **Emergency Treatment**

Your dental coverage includes services for emergency treatment. Because each individual dental office has its own emergency treatment procedure, you should contact your Dentist and familiarize yourself with the procedure for emergencies which occur outside your Dentist's normal business hours. Hospital or medical service emergency room expenses are not covered benefits under the dental benefits provisions set forth in this Part III.

### **Inquiries/Complaints**

You are encouraged to contact Delta Dental when you have a question concerning a particular claim. Your inquiry should be directed to the Customer Service Department of Delta Dental of Kansas, Inc., in Wichita, Kansas, and should include all of the following information:

1. Employee group number and identification number.
2. Patient name and birth date.
3. Dentist name and license number.
4. Claim number.
5. Date(s) of service.
6. An explanation of the complaint or question.

Written inquiries are best submitted on the copy of the Explanation of Benefits form.

Telephone inquiries may be directed to the following numbers: in Wichita, 316-264-4511, or outside of the Wichita area, 1-800-234-3375.

If you have complaints about Delta Dental or about services provided by a Dentist under the dental program, you are encouraged to write to the Customer Service Department, Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, Kansas 67278-9769.

You may also telephone the Customer Service Department using any of the numbers identified above. Complaints or inquiries may also be presented in person at the business office of Delta Dental of Kansas, Inc., which is located at 1010 N. Main St., Wichita, Kansas 67203-3615.

Delta Dental may request additional information or documents, if necessary for a full and fair review of your complaint. Delta Dental may also refer some matters to the dental licensing board or to the applicable state dental association peer review system.

Normally, you will receive a written acknowledgment of your inquiry or complaint within 20 days of receipt unless your complaint or inquiry has been referred to a review committee or unless other unusual circumstances arise, in which case, you will be advised of the delay. See Part V of this booklet for the Plan's Claims and Appeals Procedures.

### **Regional Consultants**

As Delta Dental is aware that the review of a claim form may not be sufficient to come to a decision in all cases, Delta Dental will rely on the council of regional consultants to examine patients clinically.

The treating Dentist is always notified by Delta Dental if a patient is being selected for examination by a regional dental consultant. Routine pre- and post-treatment examinations are made to determine contractual benefits and to verify that the treatment was provided and meets the accepted standards of the profession. When appropriate, examinations may also be conducted at the request of the patient or a treating Dentist.

### **Appeals to the Trust Fund**

If your claim for benefits is denied, you may appeal the decision to Delta Dental. The Claims and Appeals Procedures described in Part V of this Plan booklet will apply to your appeal for dental benefits.

### **Plan's Right to Information**

As condition precedent to the approval of claims hereunder, Delta Dental, upon its request, shall be entitled to receive from any attending or examining Dentist, or from hospitals in which a Dentist's care is rendered, such information and records relating to attendance to or examination of, or treatment rendered to, you as is helpful in the administration of your claim. Delta Dental, at its own expense, shall have the right and opportunity to cause you to be examined when and so often as it reasonably requires during the pending of a claim and the right and opportunity to make an autopsy if it is not prohibited by law.

### **Definitions**

For the purpose of the Description of Dental Benefits in this Part III of the Plan booklet, the following definitions shall apply:

1. "Cosmetic Surgery" means those services provided by Dentists for the purpose of improving the oral appearance when the form and function are otherwise satisfactory. The determination of whether services are "Cosmetic" shall be made by Delta Dental in its discretion.
2. "Covered Dental Services" means those dental services, procedures, and products that are covered by Delta Dental, in whole or in part, pursuant to the terms of the Plan.
3. "Dentist" means any duly licensed dentist or other duly licensed person who performs the service for which the payment may be made by Delta Dental under the terms of the Plan if such service is performed with the lawful scope of that person's license.
4. "Injury" means physical or traumatic damage or harm, accidental in its origin and character, in the sense that it is the result of a sudden mishap occurring by chance, unexpectedly, and not in the usual course of events, at a particular time and place.
5. "Participating Dentist" means any duly licensed person legally entitled to practice dentistry at the time and in the place the dental services are performed and who has agreed to render services in accordance with terms and conditions established by Delta

Dental and has satisfied Delta Dental that he or she is in compliance with such terms and conditions.

6. “Maximum Plan Allowance” shall be defined as the lesser of the following:
- (a) Participating Dentist:
    - (i) the fee submitted by the Participating Dentist for the dental procedure;
    - (ii) the fee that such Participating Dentist has filed with Delta Dental for the dental procedure, if any; or
    - (iii) the Delta Dental Participating Dentist Maximum Fee.
  - (b) Non-Participating Dentist:
    - (i) the fee submitted by the Non-Participating Dentist for the dental procedure; or
    - (ii) the Delta Non-Participating Dentist Maximum Fee.

**List of Dental Benefits**

If you receive a benefit listed below, the Plan will pay the percentage indicated below of the Maximum Plan Allowance for the service provided.

**Diagnostic and Preventive**

- 100% I. DIAGNOSTIC: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required:
  - Oral evaluations – once each six months.
  - Bitewing x-rays – bitewings once each six months for dependents under age 18 and once each 12 months for adults age 18 and over.
- 80% II. X-RAYS: Provides for the following:
  - Diagnostic x-rays – intraoral periapical, unlimited frequency.
  - Full mouth or panoramic x-rays – once each five years.
- 100% III. PREVENTIVE: Provides for prophylaxis (cleanings) – once each six months.
- 80% IV. PREVENTIVE: Provides for the following:
  - Topical Fluoride – once each six months for dependent children under age 19.

- Space Maintainers for dependent children under age 14 and only for premature loss of primary molars.
- Sealants – one per tooth per lifetime for dependent children under age 16 when applied only to permanent molars with no caries (decay) or restorations on the occlusal surface and with the occlusal surface intact.

**Basic**

- 80% V. ANCILLARY: Provides for emergency examination(s) by the Dentist for the relief of pain.
- 80% VI. ORAL SURGERY: Provides for extractions and other oral surgery including pre- and post-operative care.
- 80% VII. REGULAR RESTORATIVE DENTISTRY: Provides amalgam (silver) restorations, composite (white) resin restorations on anterior (front) teeth only; and stainless steel crowns for dependents under age 12.
- 80% VIII. ENDODONTICS: Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once in any 24-month period, per tooth.
- 80% IX. PERIODONTICS: Includes the following:
- Procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings.
  - Surgical periodontal procedures.

**Major**

- 50% X. SPECIAL RESTORATIVE DENTISTRY: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.
- 50% XI. PROSTHODONTICS: Includes the following:
- Bridges, partial and complete dentures.
  - Repairs and adjustments of bridges and dentures.
  - Implants.

**Orthodontics**

50% XII. **ORTHODONTICS:** Includes orthodontic appliances and treatment, interceptive and corrective, for dependent children under age 19. Subject to limitations in “Exclusions and Limitations” Section.

**Deductible Limitations**

There are no deductible limitations for services provided by Participating Dentists.

For services provided by Non-Participating Dentists, a \$75 per individual, \$150 per family deductible limitation will apply for all benefits provided in the List of Dental Benefits, with the exception of those benefits specified in items I, II, III, and IV.

**Maximum Benefit Per Person**

The maximum benefit payment for all covered dental procedures other than orthodontics for each person in any one calendar year is \$1,500. The maximum payment for all covered orthodontic procedures for each eligible child under age 19 in his or her lifetime is \$1,500. Amounts paid for orthodontic treatment will not count against a person’s annual maximum dental benefit.

**Dental Exclusions and Limitations**

Exclusions. The dental benefits and services provided shall NOT include the following:

- A. Coverage for any patient who has been, but no longer is, a participant in the Plan.
- B. Benefits or services for injuries or conditions compensable under worker’s compensation or employer’s liability laws; or benefits or services which are available from any federal or state government agency, or similar entity.
- C. Benefits, services, or appliances which are determined by Delta Dental to be for cosmetic purposes.
- D. Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the patient became eligible for benefits hereunder.
- E. Prescription drugs, premedications and relative analgesia, including nitrous oxide; hospital, healthcare facility, or medical emergency room charges; laboratory charges; anesthesia for restorative dentistry; and preventive control programs.
- F. Charges for failure to keep a scheduled visit and charges for completion of forms.
- G. Appliances or restorations for altering vertical dimension; restoring occlusion; replacing tooth structure lost by attrition, abrasion, bruxism, erosion abfraction, or corrosion; for splinting or equilibration.
- H. Dental care injuries or disease caused by riots or any form of civil disobedience if the claimant was a participant therein; war or act of war (whether declared or undeclared)

while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.

- I. Temporary services and procedures, including, but not limited to, temporary prosthetic devices.
- J. Any dental services, procedures, or products for which no benefit is provided, in whole or in part, under the terms of the Agreement between Delta Dental and the Fund.
- K. Crowns and endodontic treatment in conjunction with an over denture.
- L. Replacement of lost or stolen dentures or charges for duplicate dentures.
- M. No benefits are payable for accidental bodily injuries arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used-including such benefits mandated by law) of any automobile policy.
- N. Any benefit, procedure or service, to treat, modify, correct or change an existing condition or status caused or contributed to by prior medical or dental treatment, when prior treatment was performed in accordance with then generally accepted standards of medicine or dentistry in the local community where performed.
- O. Dental benefits and services which are not completed.
- P. Treatment rendered outside of the United States or Canada.
- Q. Services performed for the purpose of full mouth reconstruction are not Covered Dental Services unless shown as a Covered Dental Service in the List of Dental Benefits. For example, extensive treatment plans involving 10 or more crowns or units of fixed bridgework are considered full mouth reconstruction.
- R. Benefits or services for control of harmful habits.
- S. Diagnosis or treatment of temporomandibular joint dysfunction.

Limitations. The dental benefits and services provided shall be limited as follows:

- A. If a more expensive Covered Dental Service is provided than Delta Dental determines to be the least costly professionally accepted treatment, Delta Dental will pay the applicable benefit for the Covered Dental Service which is needed to achieve reasonable functionality.
- B. Only the costs of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are covered under the Plan, and then only if specifically included as a Covered Dental Service in the List of Dental Benefits.

- C. Bitewings taken within 12 months of a full mouth series of x-rays will be disallowed.
- D. A panoramic film in conjunction with a full mouth series of x-rays is not a separate benefit.
- E. A seven vertical bitewing series is limited to once every two years.
- F. Restoration of surfaces on teeth are limited to only once or twice within a 24-month period dependent upon the anatomy of the tooth. Restorations on the same tooth done within 24 months after a crown is seated are subject to frequency limitations.
- G. Recementation of space maintainers are limited to once per arch or quadrant per lifetime.
- H. Inlays will automatically receive benefits equal to the corresponding surface of a filling.
- I. Individual crowns are limited as follows:
  - 1. Individual crowns on the same tooth are limited to only once in any five-year period unless needed because of Injury. This time period is to be measured from the date the crown was supplied. If a crown is placed on a tooth which has had a restoration in the previous 24-month period, benefits paid for the crown are reduced by the benefit paid for the prior restoration.
  - 2. Porcelain crowns, porcelain fused to metal, or resin processed to metal type crowns are not covered for any person under 12 years of age.
  - 3. Recementation of a crown is limited to only once in a lifetime.
  - 4. Repairs per crown are limited to two in a 12-month period.
  - 5. Stainless steel crowns are limited to once in a 24-month period when placed on a primary tooth. If used as a permanent crown, the limitations of subparagraphs 1; 2; 3; and 4 of this subsection I will apply.
  - 6. Core build-ups, including pins, are limited to permanent teeth having insufficient tooth structure to build a crown.
- J. Prosthodontics are limited as follows:
  - 1. Not more than one full upper and one full lower denture shall be constructed in any five-year period for any one person. This time period is to be measured from the date the denture was last supplied to the person.
  - 2. A removable prosthetic or fixed prosthetic device, including bridges or implants, or full upper or full lower dentures, may not be provided for any person more often than once in any five-year period. This time period is to be measured from the last date of service the removable prosthetic or fixed prosthetic device,

- including bridges or implants, or full upper or full lower dentures was last supplied.
3. Denture reline and rebase is limited to only once in any 36-month period for any one person.
  4. Denture adjustments are limited to only two times in any 12-month period for any one person.
  5. Crowns when used for abutment purposes are covered at the same co-payment percentage as provided under the Plan for bridges and complete and partial dentures.
  6. Recementation of a bridge is limited to only once in a lifetime.
  7. If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial towards the procedure submitted. If a fixed bridge or other more expensive procedure is selected, an allowance for a partial denture is made to restore the arch to contour and function.
  8. Only two repairs per prosthesis, such as bridges, partials, or dentures, will be allowed in a 12-month period.
  9. Tissue conditioning is limited to no more than two per arch each 36 months.
  10. Dental implant procedures and associated services will be a Covered Dental Service, subject to the frequency in paragraph 2 above, and the following limitations:
    - a. Coverage should be predetermined and is limited to those persons age 16 and over. They do not need to be totally edentulous, meaning there may still be natural teeth in the arch for which the dental implants are being contemplated.
    - b. The Dentist should submit to Delta Dental a written report of recommended treatment setting forth the type and number of implants to be used, radiographs to support the dental necessity of the implant procedures as required by Delta Dental, and the proposed fees for the entire procedure.
    - c. As determined by Delta Dental, the Covered Dental Services may include, but are not limited to, consultations and surgical placement of implant devices (including the associated device and/or prosthesis) provided in conjunction with the dental implant procedures.
    - d. Payments are limited to the lesser of: (i) \$1,500, or (ii) the amount determined by Delta Dental to be allowable for dentures that are conventionally constructed using standard procedures, and which are of

the same magnitude, i.e. complete upper, complete lower or complete upper and lower, as appropriate.

- K. Payment for periodontic procedures is limited to only once in any 24-month period for all non-surgical periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subject to the same limitations and is limited to one per lifetime; periodontal maintenance which is limited to once in any six-month period; and crown lengthening which carries no frequency limitation. For surgical periodontal procedures, when covered, payment is limited to only once in any 24-month period.
- L. Composite (white) fillings are covered on anterior (front) teeth. The Plan will provide benefits in an amount up to the Maximum Plan Allowance (MPA) for an equal surface amalgam (silver) filling on posterior (back) teeth.
- M. Payment for anesthesia and IV (intravenous) sedation is limited to only for surgical extractions which are Covered Dental Services and is limited to a maximum of one hour, per episode.
- N. Orthodontic Services are Covered Dental Services, subject to the following limitations:
  - 1. Plan benefits will cease on the date of termination if the treatment plan is terminated for any reason, or the person is no longer eligible for benefits before completion of the case. Treatment may be terminated by the Dentist, by written notification to Delta Dental and to the person, for lack of person interest and cooperation.
  - 2. Related services, such as but not limited to, x-rays, extractions, and study models, shall be payable at the orthodontic co-insurance percentage.
  - 3. The repair or replacement of an orthodontic appliance is not a Covered Dental Service.
  - 4. Maximum Benefit for Orthodontic Services:
    - a. Payment for Orthodontic Services shall be limited to \$1,500. Payment for Orthodontic Services shall be made on a monthly basis as determined by the number of months of treatment established by the Dentist. Payment of initial fees may be made at the time of the treatment.
    - b. If a deductible applies, Delta Dental shall not be obligated to pay for, or otherwise discharge, in whole or in part, any fee, up to the deductible.
    - c. The Maximum Benefit for Orthodontic Services will be reduced by all amounts previously paid as orthodontics benefits by Delta Dental or by any other dental plan or arrangement.

- d. Rebonding, recementing and/or repair of fixed retainers must be included in the Orthodontics case fee. A separate fee submitted by the Orthodontics provider is not allowed. In cases of excessive or continuous repairs/recements/rebonds, individual consideration may be given to allow the service as a Covered Dental Service.

Certain dental benefits and services may be disallowed under the Plan. When dental benefits or services are disallowed, the fees associated with those items are neither covered by Delta Dental nor collectable from the person by a Participating Dentist. Disallowed services will be so indicated on the Explanation of Benefits.

**Termination of Benefits**

If your coverage under the Plan is terminated, operative procedures then in progress which are completed within 30 days of the termination of coverage and submitted for payment within six months of such termination shall be covered. For this purpose, operative procedures are defined as and limited to individual crowns; dentures, partial and complete; and bridges and are considered in progress only if all procedures for commencement of lab work have been completed.

**Coordination of Benefits**

All dental benefits will be subject to the coordination of benefits and subrogation provisions explained in the General Information Section in Part I of this Plan booklet.

## **PART IV**

### **SCHEDULE OF OTHER WELFARE BENEFITS PROVIDED DIRECTLY BY THE FUND**

The following benefits are administered by the Plan Administrator. Any claims filed for the following benefits or any questions you have regarding these benefits should be addressed to the Administrator at the address and phone number set forth in the Section of Part I of this booklet titled “**Information About the Plan.**”

1. Death Benefits & AD&D.
2. Weekly Disability Benefits.
3. Frozen Retiree Subsidy Program.
4. Vision Benefits.

### **CLAIMING BENEFITS PROVIDED DIRECTLY BY THE TRUST FUND**

**Initial Claim Determination.** Weekly Disability Benefits, Frozen Retiree Subsidy Program Benefits, Vision Benefits, Death Benefits, and Accidental Death and Dismemberment Benefits will be paid directly from the Trust Fund, rather than through an insurance company. Claims should be submitted to the Plan Administrator on forms he or she will provide. You must submit a claim for these benefits within one year and three months after you received a service. A decision will be made on each claim within a reasonable time after it is received. We anticipate most claims will be approved, but if a claim is wholly or partially denied, the Plan’s “Appeals Procedure,” described in Part V of this Plan booklet, will be utilized.

### **DEATH BENEFITS**

A death benefit is paid to your beneficiary directly by the Plan in the amount of \$15,000, in the event of your death while covered under the Plan. This benefit is provided to you on or off the job. It is reduced by 35% at age 65. You may designate, in a form specified by the Plan Administrator, one or more beneficiaries, who will be paid the death benefit in the event of your death. If no designated beneficiary should survive you, payment will be made by the Trust Fund to your spouse. If your spouse does not survive you, the death benefit will be paid directly to your estate.

You may change your beneficiary by filing a written notice with the Plan Administrator. No beneficiary change is effective until the Plan Administrator receives notice of such change.

### **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (AD&D)**

An accidental death and dismemberment benefit is provided for eligible employees directly by the Plan, subject to the following provisions:

Covered Losses. The Plan will pay the amount shown in the AD&D Schedule, below, upon receipt of satisfactory written proof that you have sustained any of the losses shown in that Schedule, provided all of the following conditions are met:

- The loss must be caused solely and directly by accidental bodily injuries, and the loss must occur independently of all other causes;
- The accident must occur while you are covered under the Plan; and
- The loss must occur within 365 days after the date of the accident.

Exclusions. No payment will be made if either the accidental bodily injuries or the loss is caused or contributed to by any of the following:

- Insurrection, war, or act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict with organized forces of a military nature;
- Suicide or any other intentionally self-inflicted injury, while sane or insane;
- Committing or attempting to commit an assault or a felony or your active participation in a violent disorder or riot;
- The voluntary use or consumption of any poison, chemical compound, or drug (including, but not limited to prescribed medications), unless used or consumed in accordance with directions of a physician;
- Any sickness or pregnancy existing at the time of the accident;
- Heart attack or stroke; or
- Medical or surgical instruments.

Seat Belt Benefit. The Plan will pay to your beneficiary an additional \$5,000 if you are killed in an automobile accident and you were wearing a seat belt at the time of the accident. A copy of the police report must be submitted with the claim.

Beneficiary Provisions. You may designate, in a form specified by the Plan Administrator, one or more beneficiaries, who will be paid the AD&D benefit in the event of your death. If no designated beneficiary should survive you, payment will be made by the Trust Fund to your spouse. If your spouse does not survive you, the AD&D benefit will be paid directly to your estate.

Your beneficiary designation should be kept up to date to assure that benefits are paid in accordance with your wishes. You may change your beneficiary by filing written notice with the Plan Administrator. No beneficiary change is effective until the Plan Administrator receives notification of such change.

### **SCHEDULE OF AD&D BENEFITS**

The Schedule of Accidental Death and Dismemberment benefits is as follows:

Loss of Life	\$15,000
Loss of both hands, both feet, or irrecoverable sight of both eyes	\$10,000
Loss of one hand, one foot, or irrecoverable sight of one eye	\$5,000
Seat Belt Benefit	\$5,000

These benefits are payable whether or not the accident occurs during the course of your employment.

### **WEEKLY DISABILITY BENEFITS**

Only eligible employees other than those making payments to the Plan on their own behalf may receive weekly income benefits. If you become totally disabled because of a non-occupational disability, and remain under the care of a doctor (M.D. or D.O.), you will receive the weekly benefits set out in the Schedule of Benefits. No benefit is payable for any period for which you are entitled to receive workers' compensation benefits. The benefit payable under this provision will be paid to you after the waiting period specified in the Schedule. For any separate period of disability, payments will continue until the total disability ends or you reach the end of the benefit period, whichever happens first.

You are totally disabled if you cannot perform the duties of your own occupation or any other work for remuneration or profit because of injury, sickness, or pregnancy.

No weekly income benefit will be paid under this Plan for any period in which you are disabled because of an intentionally self-inflicted injury, war or any act of war, the commission of a felony, participation in a riot, or participation in aeronautic activities except as a passenger. The Plan Administrator reserves the right to request a physical examination by a physician of the Plan Administrator's choosing, as a prerequisite to provide further weekly income benefits.

Benefits begin on the eighth day of continuous disability due to accident or sickness.

The maximum for each period of disability is 182 days. Two or more periods of disability due to the same cause are considered one period of disability, unless they are separated by your return to full-time work for a continuous period of at least 30 days.

If weekly income is paid for the maximum number of days, a new period of disability due to the same or a related injury or sickness will not be allowed, unless separated by your return to the full-time duties of your regular occupation for a continuous period of at least 30 days.

## SCHEDULE OF DISABILITY BENEFITS

Weekly Disability Benefit	
Occupational Disabilities	None
Non-Occupational Disabilities	\$300* or 66-2/3% of weekly compensation, whichever is less
Waiting Period	
Accident 7 days	
Sickness 7 days	

## RETIREE BENEFIT PROGRAM

### **Effective January 1, 2010**

Retirees and their spouses from age 60 to age 65 may elect to continue coverage under the Plan's Retiree Benefit Program, but only if they are covered by the Plan at the time they attain age 60. Participants in the Retiree Benefit Program will be entitled to the same benefits as actively working employees, including the Plan's Health Care Benefits, Vision Benefit, Dental Benefits, Life Insurance Benefit, and Accidental Death and Dismemberment Benefit. The level of coverage will be the same as that provided to active employees under the Plan. However, participants in the Retiree Benefit Program will not be entitled to the Plan's Weekly Disability Benefit.

Retirees will not be eligible for the Retiree Benefit Program if they become eligible for coverage under another employer group health plan or Medicare or Medicaid. When a retiree's coverage under the Retiree Benefit Program ends, the spouse of the retiree will continue to be eligible for coverage under the Retiree Benefit Program until the earlier of the third anniversary of the date the retiree's coverage ended, or the first day of the month in which the spouse attains age 65 or otherwise becomes ineligible.

The monthly charge for continued coverage under the Retiree Benefit Program will be determined by the Trustees, and will be the same for all similarly situated individuals electing the same type of coverage under this provision. If the premium is not paid in a timely manner, or if coverage is terminated for any other reason, the retiree (and his or her spouse) will not be eligible to reenroll in the Retiree Benefit Program. In addition, a retiree (or his or her spouse) who elects coverage under the Retiree Benefit Program will not be offered COBRA continuation coverage at the time he or she loses coverage under the Retiree Benefit Program.

Prior to January 1, 2010, the Board of Trustees provided a subsidy to cover part of the cost of individual insurance policies for certain retirees (and their spouses) from age 60 until age 65 (the "Retiree Subsidy Program"). All retirees (and their spouses) who were participating in the Retiree Subsidy Program were given the opportunity to elect (no later than December 31, 2009) between continuing to participate in the Retiree Subsidy Program described below or

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\* Weekly Disability payments are subject to FICA Tax.

participating instead in the Retiree Benefit Program. Such elections are irrevocable. Please call the Plan Administrator for further information.

Note: Although the Trustees currently intend to continue this Retiree Benefit Program, they reserve the right to cancel or amend the Program at any time.

### **FROZEN RETIREE SUBSIDY PROGRAM**

All retirees (and their spouses) participating in the Retiree Subsidy Program as of December 31 2009, were given the opportunity to elect (no later than December 31, 2009) between continuing to participate in the Retiree Subsidy Program or participating instead in the Retiree Benefit Program described above. Such elections are irrevocable.

A retiree (and his or her spouse) who elected to continue to participate in the Retiree Subsidy Program after December 31, 2009, will receive a subsidy in an amount equal to the 2009 subsidy. The amount of the subsidy will not increase even if the retiree's (or his or her spouse's) premium for his or her individual policy increases. Retirees shall not be eligible for subsidies if they become eligible for coverage under another employer group health plan or Medicare or Medicaid. When the period during which a retiree is provided such a subsidy ends, the spouse of the retiree will continue to be eligible for the retiree subsidy for a period extending to the earlier of the third anniversary of the date the retiree's subsidy ended, or the first day of the month in which the spouse attains age 65 or otherwise becomes ineligible. Please call the Plan Administrator for further information.

### **VISION BENEFITS**

The Plan will pay a vision benefit of up to \$600 per family for vision expenses each calendar year. Claim forms are available from the Plan Administrator or online at [www.PPI-FUND.ORG](http://www.PPI-FUND.ORG). A copy of the lens prescription, and an itemized statement must be submitted to the Plan Administrator with the claim form.

This benefit covers:

- Eye exams;
- New or replacement prescription lenses;
- Contact lenses; and
- Frames for prescription glasses.

**PART V**

**CLAIMS AND APPEALS PROCEDURES**

The Claims and Appeals Procedures described in this Part V apply only to certain benefits provided directly by the Trust Fund, and to benefits provided by Cigna, but not to insured benefits, such as certain life insurance and accidental death and dismemberment benefits, provided by an insurance company.

This chart gives you an outline of some of the key points of the Plan’s claims and appeals procedure. A copy of the complete procedure is detailed below.

<b>CLAIMS PROCEDURES CHART</b>					
	<b>Where to File Claims</b>			<b>Filing Deadlines</b>	<b>Notification of Benefit Determination</b>
	<b>Benefits Administered by Cigna</b>	<b>Dental Benefits</b>	<b>All Other Benefits</b>		
<b>Urgent Care Claim<sup>1</sup></b>	<u>Medical</u> Cigna Healthcare P.O. Box 182223 Chattanooga, TN 37422-7223 (800) 244-6224 (800-CIGNA24)  <u>Prescription Drug</u> Cigna Pharmacy Service Center P.O. Box 188053 Chattanooga, TN 37422-8053 (800) 244-6224 (800-CIGNA24)	Delta Dental of Kansas, Inc. P.O. Box 49198 Wichita, KS 67201-9198 (316) 264-4511 or (800) 234-3375	Plan Administrator 505 S. Broadway Suite 117 Wichita, KS 67202-3922 (316) 264-2339 or (800) 423-6517	Before expense is incurred	Generally, not later than 72 hours after receipt of the claim
<b>Pre-Service Claim<sup>1</sup></b>				Before expense is incurred	Not later than 15 days after receipt of the claim (may be extended an additional 15 days)
<b>Post-Service Claim</b>				Within one year and 90 days of the date the expense is incurred	Not later than 30 days after receipt of the claim (may be extended an additional 15 days)
<b>Disability Claim</b>				Within one year and 90 days of the date the expense was incurred	Not later than 45 days after receipt of the claims (may be extended an additional 60 days)

<sup>1</sup>Urgent care and pre-service claims only involve expenses for which the Plan requires approval before the expenses are incurred.

<b>APPEALS PROCEDURES CHART</b>					
	<b>Where to File Appeals</b>			<b>Filing Deadlines</b>	<b>Notification of Appeal Determination</b>
	Benefits Administered by Cigna	Dental Benefits	All Other Benefits		
Urgent Care Appeal <sup>2</sup>	<u>Medical</u> Cigna Healthcare P.O. Box 182223 Chattanooga, TN 37422-7223 (800) 244-6224 (800-CIGNA24)  <u>Prescription Drug</u> Cigna Pharmacy Service Center P.O. Box 188053 Chattanooga, TN 37422-8053 (800) 244-6224 (800-CIGNA24)	Delta Dental of Kansas, Inc. P.O. Box 49198 Wichita, KS 67201-9198 (316) 264-4511 or (800) 234-3375	Plan Administrator 505 S. Broadway Suite 117 Wichita, KS 67202-3922 (316) 264-2339 or (800) 423-6517	Before expense is incurred	Not later than 72 hours after receipt of the appeal
Pre-Service Appeal <sup>2</sup>				Before expense is incurred	Not later than 30 days after receipt of the appeal
Post-Service Appeal				Within 180 days following receipt by you of an adverse benefit determination	Not later than 60 days after receipt of the appeal
Disability Appeal				Within 180 days following receipt by you of an adverse benefit determination	Not later than 45 days after receipt of the appeal (may be extended an additional 45 days)

<sup>2</sup>Urgent care and pre-service claims only involve expenses for which the Plan requires approval before the expenses are incurred.

## CLAIMS AND APPEALS PROCEDURES

1. **Filing the Claim.** A claim is a request for a Plan benefit made by a claimant on a form provided by the Plan Administrator or, in the case of an urgent care claim, either orally or on such a form. References in this Part V of the Plan booklet to the Plan Administrator mean: with respect to claims for health care benefits described in Part II — Cigna; with respect to claims for dental benefits described in Part III — Delta Dental of Kansas, Inc.; and with respect to the other welfare benefits described in Part IV — the Plan Administrator. A claimant is a person who participates or claims to participate in the Plan. Claims for medical benefits administered by Cigna are filed directly with Cigna and will be decided by Cigna. Claims for dental benefits are filed directly with Delta Dental of Kansas, Inc. and will be decided by Delta Dental of Kansas, Inc. All other medical claims should be filed with the Plan Administrator. For such a form to be considered, the claimant must mail or deliver it, completed and executed, to the appropriate entity at one of the following addresses:

<u>Claims for Benefits Administered by Cigna</u>	<u>Claims for Benefits Administered by Delta Dental</u>	<u>All Other Claims</u>
<i>Medical Benefits:</i> Cigna Healthcare P.O. Box 182223 Chattanooga, TN 37422-7223	Delta Dental of Kansas, Inc. P.O. Box 49198 Wichita, KS 67201-9198	Plan Administrator 505 S. Broadway Suite 117 Wichita, KS 67202-3922
<i>Prescription Drug Benefits:</i> Cigna Pharmacy Service Center P.O. Box 188053 Chattanooga, TN 37422-8053		

For an urgent care claim to be considered, it must be communicated to any of the following, using any of these phone numbers:

<u>Claims for Benefits Administered by Cigna</u>	<u>Claims for Benefits Administered by Delta Dental</u>	<u>All Other Claims</u>
(800) 244-6224 (800-CIGNA24)	(316) 264-4511 or (800) 234-3375	(316) 264-2339 or (800) 423-6517

The Plan Administrator shall decide the claim. None of the following constitutes a claim:

- (a) The presentation of a prescription to a pharmacy to be filled at a cost to you determined by reference to a formula or schedule established in accordance with the terms of the Plan and with respect to which the pharmacy exercises no discretion on behalf of the Plan;
- (b) A request for prior approval of a benefit or service when the prior approval is not required under the terms of the Plan; or

- (c) Interactions between you and Plan providers under arrangements by which the providers provide services or products at a predetermined cost to you and with respect to which the providers exercise no discretion on behalf of the Plan.
2. **Urgent Care Claims.** A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
- (a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,
  - (b) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Except as provided below, whether a claim is a “claim involving urgent care” is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant's medical condition determines is a “claim involving urgent care” shall be treated as a “claim involving urgent care” for purposes of this Plan. The nature of a claim or a request for review of an adverse benefit determination shall be judged as of the time the claim or review is being processed. If requested services have already been provided between the time the claim was denied and the request for review was filed, the claim no longer involves urgent care. The Plan Administrator may request specific information from the claimant regarding whether and what medical circumstances exist that may give rise to a need for expedited processing of the claim. A post-service claim never constitutes a claim involving urgent care.

In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant as soon as possible, but not later than 24 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. Notification of any adverse benefit determination pursuant to this subsection shall be made in accordance with the provisions of subsection 9 of this Part V. The Plan 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 the Plan's receipt of the specified information, or the end of the period afforded the claimant to provide the specified additional information.

3. **Pre-Service Claims.** The term “pre-service claim” means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit in whole or in part on approval of the benefit in advance of obtaining medical care. In the

case of a pre-service claim, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond 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. 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. Notification of any adverse benefit determination pursuant to this subsection shall be made in accordance with subsection 9 of this Part V.

4. **Failure to Follow Pre-Service Claim Procedures.** In the case of a failure by a claimant to follow the Plan's procedures for filing a pre-service claim, within the meaning of subsection 3 of this Part V, the claimant shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant. This subsection shall apply only in the case of a failure that:

- (a) Is a communication by a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and
- (b) Is a communication that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

5. **Concurrent Care Decisions.** If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then any reduction or termination by the Plan of such course of treatment (other than by an amendment of the Plan or its termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan Administrator shall notify the claimant, in accordance with the provisions of subsection 9 of this Part V, 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. Moreover, any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is 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. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in compliance

with the provisions of subsection 9 of this Part V, and the appeal shall be governed by subsections 14, 15 or 16 of this Part V, as appropriate.

6. **Post-Service Claims.** The term “post-service claim” means any claim for a benefit under the Plan that is not a pre-service claim, as provided in subsection 3 of this Part V. In the case of a post-service claim, the Plan Administrator shall notify the claimant, in accordance with subsection 9 of this Part V, of the Plan’s adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan 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. If such an extension is necessary, due to a failure of a claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.
7. **Notification for Disability Claims.** In the case of a claim for disability benefits, the Plan Administrator shall notify the claimant, as provided in subsection 9 of this Part V, of the Plan Administrator’s adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan Administrator. This period may be extended by the Plan Administrator for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan Administrator, and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring an extension of time and the date by which the Plan Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan Administrator expects to render a decision. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent the decision on the claim, and the additional information needed to resolve those issues. The claimant will be afforded at least 45 days within which to provide the specified information.
8. **Calculating Time Periods for Claims.** For purposes of subsections 2 through 7 of this Part V, 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 procedures set forth in subsection 1 of this Part V, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event a period of time is extended as permitted by subsections 3, 6, or 7 of this Part V due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for

additional information.

9. **Notification of the Decision.** The Plan Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by regulations issued by the Department of Labor under ERISA. The notification shall set forth in a manner calculated to be understood by the claimant:
- (a) The specific reason or reasons for the adverse determination;
  - (b) Reference to the specific Plan provisions on which the determination is 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, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal;
  - (e) In the case of an adverse benefit determination,
    - (i) 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 similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request; or
    - (ii) 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; and
  - (f) In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

In the case of an adverse benefit determination concerning a claim involving urgent care, the information described in this subsection may be provided to the claimant orally within the timeframe prescribed in subsection 2 of this Part V, provided that a written or electronic notification in accordance with this subsection is furnished to the claimant not later than three days after the oral notification.

10. **Authorized Representative.** An authorized representative of the claimant may act on

his or her behalf in pursuing a benefit claim or appeal of an adverse benefit determination. The Plan Administrator may require, as a prerequisite to dealing with a representative, that the claimant verify in writing authority of the representative to act on behalf of the claimant. In the case of a claim involving urgent care, a physician or other health care professional licensed, accredited or certified to perform specified health services consistent with State law, with knowledge of the claimant's medical condition, may act as the authorized representative of the claimant. An assignment of benefits by a claimant to a health care provider does not constitute the designation of an authorized representative.

11. **Consistency.** The Trustees, the Plan Administrator, or both, shall conduct or have conducted on their behalf periodic reviews to verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan's provisions have been applied consistently with respect to similarly-situated claimants.
12. **Deciding the Appeal.** A claimant may appeal an adverse benefit determination with respect to a medical benefit administered by Cigna to Cigna. A claimant may appeal an adverse benefit determination with respect to a dental benefit to Delta Dental of Kansas, Inc. A claimant may appeal an adverse benefit determination with respect to all other benefits to the Trustees. The claimant may appeal by mailing or delivering to the Plan Administrator a written notice of appeal. The claimant may submit written comments, documents, records, or other information relating to the claim for benefits to the Plan Administrator. The Plan Administrator shall provide to the claimant, 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. Whether a document, record or other information is relevant to a claim for benefits shall be determined in accordance with standards issued by the Department of Labor.

Cigna shall decide appeals with respect to an appeal of a medical benefit administered by it. Delta Dental of Kansas, Inc., shall decide appeals with respect to an appeal of a dental benefit. The Trustees shall decide all other appeals. The person or persons who decides the appeal is referred to in this Part V as the "Appellate Authority."

The Appellate Authority's decision shall take 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 the initial benefit determination. The Appellate Authority will not, however, consider a claimant's appeal unless the Plan Administrator receives it within 180 days following receipt by the claimant of a notification of an adverse benefit determination. The appeal will be considered by the Appellate Authority without deference to the original decision made by the Plan Administrator.

In deciding an appeal of any adverse benefit determination where the determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Appellate Authority shall consult with a health

care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Plan Administrator shall, when requested to do so by a claimant, identify the 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. Any health care professional engaged for purposes of a consultation under this subsection shall be an individual 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.

**NO ACTION AT LAW OR IN EQUITY SHALL BE BROUGHT TO RECOVER ANY BENEFIT UNDER THE PLAN UNTIL THE RIGHTS TO APPEAL DESCRIBED IN THIS PART V HAVE BEEN EXERCISED AND THE BENEFITS REQUESTED IN THE APPEAL HAVE BEEN DENIED IN WHOLE OR IN PART.**

13. **Appeal of Urgent Care Claims.** In the case of a claim involving urgent care:
  - (a) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
  - (b) 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.
14. **Notification of the Decision on Appeal; Urgent Care Claims.** In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant, in accordance with the provisions of subsection 18 of this Part V, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the Plan.
15. **Notification of the Decision on Appeal; Pre-Service Claims.** In the case of a pre-service claim that is not a claim involving urgent care, the Plan Administrator shall notify the claimant, in accordance with subsection 18 of this Part V, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. That notification shall be provided not later than 30 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.
16. **Notification of the Decision on Appeal; Post-Service Claims.** In the case of a post-service claim, the Plan Administrator shall notify the claimant, in accordance with subsection 18 of this Part V, of the Plan's benefit determination on review within a reasonable period of time. That notification shall be provided not later than 60 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.
17. **Notification of the Decision on Appeal; Disability Claims.** In the case of a claim for disability benefits, the Plan Administrator shall notify the claimant, in accordance with

subsection 18 of this Part V, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. That notification shall be provided not later than 45 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination. This period may be extended by the Plan Administrator for up to 45 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan Administrator, and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring an extension of time and the date by which the Plan Administrator expects to render a decision.

18. **Content of Notification of the Decision on Appeal.** The Plan Administrator shall provide a claimant with written or electronic notification of the Plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by the Department of Labor by regulations issued under ERISA. In the case of an adverse benefit determination, the notice shall set forth, in a manner calculated to be understood by the claimant:

- (a) The specific reason or reasons for the adverse determination;
- (b) Reference to the specific Plan provisions on which the benefit determination is based;
- (c) 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 (whether a document, record or other information is relevant to a claim for benefit shall be determined by reference to regulations issued under ERISA by the Department of Labor);
- (d) A statement of the claimant's right to bring an action under Section 502(a) of ERISA;
- (e) 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 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 criterion will be provided free of charge to the claimant upon request; and
- (f) 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.

In the case of an adverse benefit determination on review, the Plan Administrator shall provide access to, and copies of, documents, records, and other information described in Paragraphs 18(c), (e) and (f) of this Part V, as is appropriate.

19. **Calculating Time Periods on Appeal.** For purposes of subsections 14, 15 and 16 of this Part V, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with subsection 12 of this Part V, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to subsection 17 of this Part V due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.
20. **Extensions of Time.** A claimant may voluntarily agree to provide the Plan additional time within which to make a decision on a claim or an appeal.
21. **One-Year Limitation on Legal Action.** You or your representative may not bring any lawsuit against the Plan, or a representative or fiduciary of the Plan, more than one year from the later of: (i) the date your claim is first filed, or (ii) the date the Plan renders a decision on your claim or, if you timely file an appeal with the Plan, on your appeal. Refer to subsection 12 of this Part V for a statement of the requirement that you may not bring a lawsuit against the Plan unless you fully pursue your right to appeal under this Part V.