2022 SUMMARY PLAN DESCRIPTION – PART C

IMPORTANT NOTICES TO MEMBERS REGARDING THEIR RIGHTS

SEE ALSO:

Part A for Medical and Rx Schedule of Benefits, Eligibility, and Basic Rules.

Part B for Basic Plan Rules, Definitions, Excluded Benefits, Coordination of Benefits, Subrogation, Appeals, etc.

Part C for certain provisions (like new preventive care) may have different effective dates based on plan year. Part C is maintained and updated for various required disclosure notices to keep participants informed of their rights. Your Plan was reorganized into four separate sections to make it easier to make various updates as required by Health Care Reform. Also, see the Uniform Glossary of Terms posted online at www.ktftrustfund.com.

Please refer to the Table of Contents for a list of notices by subject. Members have the right to request a copy of their Plan or specific notices by mail or email. For a hard copy, please contact the KTF Trust office. For a copy by email, contact the KTF Compliance Office at (844) 583-3863 or visit www.ktftrustfund.com.

Part D for the Dental Plan.

In case there is a discrepancy between the provisions as stated in Part C and those stated in Part A, the provisions in Part A will be controlling and shall supersede any general provisions in Part C.

Members can find a copy of their Plan (Parts A, B, C and D) online at www.ktftrustfund.com along with the **Uniform Glossary of Terms,** **Benefits at a Glance,** and **Summary of Benefits and Coverage (SBC).**

Effective Date: January 1, 2022

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INTRODUCTION AND IMPORTANT INFORMATION

This plan has been updated to comply with current laws, rules, and regulations. It is important for members to understand changes are being made continually due to the Patients' Protection and Affordable Care Act. **Since so much of the information in Part C is NEW or has been modified to incorporate changes in the rules, new language is not highlighted in Part C. Please take a few minutes to review the information in this section of the Plan.**

As new rules and/or regulations or guidance is used, changes may be implemented operationally with Plan updates being made at a later point in time. When new rules are issued, compliance dates are generally the first day of the Plan year on or following the date final rules or regulations are issued. Thus, the effective date for one plan may be different than the effective date for another plan due to different Plan years.

The Plan is organized as follows with all notices contained in this Part C. For questions on a Plan provision or benefit, call the KTF Compliance Office at (844) 583-3863.

- **Part A -** Specific or unique plan rules and the Medical and Rx Schedules of Benefits are contained in this section. This section of the Plan includes the most frequently referenced information on eligibility and benefits for members.
- **Part B** - Provides more detailed general information and plan rules such as allowable charges, appeals, eligibility, exclusions, pre-certification, subrogation, etc. In the event, there is a discrepancy between the provisions as stated in Part B and those stated in Part A, the provisions in Part A will be controlling and supersede any general provisions in Part B in all cases. The same is true if two provisions are in conflict. The most favorable interpretation for the member will be applied with respect to any specific claim or situation if there is ambiguity in the Plan.
- **Part C** - Includes all the required notices that are to be given to employees to inform them of their general rights, including notices concerning changes under the Patient's Protection and Affordable Care Act, which is also referred to as PPACA, ACA (Affordable Care Act) as well as Health Care Reform.
- **Part D** - Includes the Dental Schedule of Benefits and exclusions. Basic provisions for eligibility and general plan rules are the same as for the Group Health Plan under Parts A, B and C. Pre-certification of dental procedures is not required; benefits will be based on whether services are provided by in network or out-of-network providers.

APPEAL RIGHTS NOTICE

You should contact the KTF Compliance Office at (844) 583-3863 when you:

1. Do not understand the reason for the denial;
2. Do not understand why the health care service or treatment was not fully covered;
3. Do not understand why a request for coverage of a health care service or treatment was denied;
4. Cannot find the applicable provision in your Benefit Plan Document;
5. Want a copy (free of charge) of the guidelines, criteria, or clinical rationale that we used to make our decision; or
6. Disagree with the denial or the amount not covered, and you want to appeal;
7. If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim; and
8. If your request for service has been denied as not being "medically necessary" as defined by the Plan or as "experimental" or "investigational."

All appeals for claim denials *(or any decision that does not cover expenses you believe should have been covered)* must be sent **in writing** to the **KTF Compliance Office at 416 Creekstone Ridge, Woodstock, GA 30188** within **180-days** of the date you receive the denial. Denials or reduced payment of benefits will be as noted on your **Explanation of Benefits (EOB). Members will receive an Explanation of Benefits for every claim paid by the plan.**

An Explanation of Benefits (EOB) is provided to the primary member and to your provider when there is an assignment of benefits on the claim. Please be sure to review your EOB, especially the footnotes and remark codes indicating how a claim was paid, claim adjustments, or information needed to reprocess the claim for payment.

The KTF Compliance Office will provide a full and fair review of your claim upon appeal. If you wish your appeal to be overseen by an authorized representative, this authorization must be submitted in writing. You may also submit a general HIPAA Authorization to permit the authorized party to act on your behalf to obtain information on your claims, benefits, etc. on an ongoing basis. Any Medical Power of Attorney should be submitted to the plan.

The member, authorized representative or the provider must submit all appeals in writing along with any additional documentation to protect their rights under the Plan. You should provide the KTF Compliance Office with any additional information that relates to your claim. You may request copies of information we have pertaining to your claims.

The individuals in the compliance office are not involved in the claim payment process or the initial denial of your claim. The Compliance Department operates independently of the Claims Department and Pre-certification Department. It is their function to fairly and impartially review any appeal to determine if it was properly paid or denied and to advise you of its ultimate findings. They will also advise you of the specific language in the plan that supports the denial or claims payment as appropriate based each individual situation. When appropriate, the Compliance Department may rely on information provided by the Pre-certification Department or other Departments in reaching a final decision.

External review for adverse benefit determinations and final internal adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of covered benefits or care is available as of July 1, 2011. Under the Plan's External Review Process, your appeal will be submitted to an Independent Review Organization (IRO), one of three retained by the Plan on a rotating basis. **The decision of the IRO is binding under the Plan on both the Plan and the Member. There is a $25 filing fee payable upon request of an External Review of your claim.**

Appeal information is required to be provided in another language if 10% of the population in the county where the claimant resides speaks the same non-English language based on the percentage of the population which speaks a foreign language.

We will notify you of our decision in writing within **30-days (60-days for a complex claim)** of receipt of your written appeal. If you do not receive our decision within **60-days** of receipt of your appeal, you may be entitled to file a request for external review.

Your appeal rights under the Plan have been updated to conform to Section 2719 of the Public Health Service (PHS) Act, as added by the Affordable Care Act of 2010 (Health Care Reform Act). Your review and appeal rights are explained below and include the following 16 minimum consumer protection standards as summarized in Technical Release 2011-02:

1. The process must provide for external review of adverse benefit determinations (and final internal adverse benefit determinations) based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
2. Issuers (or plans) must be required to provide effective written notice to claimants of their rights to external review.
3. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if (a) the issuer (or plan) waives the exhaustion requirement; (b) the issuer (or plan) is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process except those failures that are based on de minimis (minimal) violations that do not cause, and are not likely to cause, prejudice or harm to the claimant; or (c) the claimant simultaneously requests an expedited internal appeal and an expedited external review.
4. The cost of an independent review organization (IRO) to conduct an external review must be borne by the issuer (or plan), although the process may require a nominal filing fee (*not to exceed $25 per appeal up to $75 during any calendar year)* from the claimant requesting external review.
5. There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review.
6. The process must allow at least four months to file a request for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.
7. The IRO must be assigned by the State or an independent entity, on a random basis or another method of assignment that ensures the independence and impartiality of the assignment process *(such as rotational assignment),* and in no event assigned by the issuer, the plan, or the individual.
8. The process must provide for the maintenance of a list of approved IROs *(only those that are accredited by a nationally recognized private accrediting organization)* qualified to conduct the external review based on the nature of the health care service that is the subject of the review.
9. Approved IROs must have no conflicts of interest that will influence their independence.
10. Claimants must be allowed to submit to the IRO additional information in writing that the IRO must consider when conducting the external review, and the claimant must be notified of the right to submit additional information to the IRO; the IRO must allow the claimant at least 5 business days to submit any additional information and any additional information submitted by the claimant must be forwarded to the issuer (or plan) within one business day of receipt by the IRO.
11. The IRO decision must be binding on the claimant, as well as the plan or issuer *(except to the extent other remedies are available under State or Federal law).* The requirement that the decision be binding does not preclude a plan or issuer from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that

denies the claim or otherwise fails to require such payment or benefits. The Plan must provide benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision.

12. For standard external review, the IRO must provide written notice to the Plan and the claimant of its decision to uphold or reverse the adverse benefit determination within no more than 45-days after the receipt of the request for external review.
13. The process must provide for an expedited external review in certain circumstances and, in such cases, provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the request for external review *(and if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision)*.
14. Plans must provide a description of the external review process in or attached to the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to participants, beneficiaries, or enrollees, substantially similar to section 17 of the NAIC Uniform Model Act.
15. The IRO must maintain written records and make them available upon request to the State, substantially similar to section 15 of the NAIC Uniform Model Act.
16. The process must follow procedures for external reviews involving experimental or investigational treatment, substantially similar to section 10 of the NAIC Uniform Model Act.

See PART B for detailed information on Appeals and Adverse Benefit Determinations.

DEPENDENT COVERAGE NOTICE

Dependent May Be Covered to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to be enrolled under their Parent(s) Plan. The initial enrollment period was effective for the first Plan year beginning on or after September 23, 2010.

Only enrolled dependent children as defined by the IRS code may be covered under the plan without regard to their dependent status, student status, income, or marital status for tax purposes. Family coverage must be elected in order to cover any dependent but there shall be no additional charge other than the normal cost for family coverage. Proof of dependent child status will be required when a child is not the natural or adopted child of the member or their legally wed spouse, such as custodial status for eligible foster children, qualifying relatives, or other child for whom the member and/or their spouse have legal custody. Notice of dependent status changes must be timely provided. *(See also QMCSO – Qualified Medical Child Support Order.)*

After the Initial Enrollment Period, a dependent to age 26 may only be enrolled during open enrollment or as a result of a Special Enrollment situation *(see Qualified Life Event Chart)* such as:

1. The loss of a dependent's other coverage through their employer that qualifies as a special enrollment situation or Qualifying Life Event (QLE);
2. If there is a change in family status of the dependent, e.g., a dependent's status changes, and they go back to school as a full-time student; or
3. Other change in status which qualifies as a special enrollment situation where the change is consistent with the qualified event. *See the Special Enrollment – QLE Chart for eligible changes.*

Notice and application for coverage must be made to the KTF Compliance Office with 60-days of the event. Coverage is effective as of the beginning of the month following any special enrollment.

Dependent Coverage Ends Automatically

1. Dependent coverage AUTOMATICALLY ends as of the earlier of the following:
2. The date coverage is terminated by the member or dependent; or
3. The last day of the month in which the dependent attains age 26.

After coverage terminates due to age, the dependent is eligible to continue coverage under COBRA for 36-months. Coverage is also available to dependents age 26 through age 29 under the NY Young Adult Option or through the Health Insurance Marketplace. For more information contact the KTF Compliance Office at (844) 583-3863.

New York Young Adult Option through Age 29

Members may apply for COBRA coverage for any "unmarried dependent" age 26 through age 29 (end of month in which age 30 is attained) if they are divorced or lose their coverage**.** Medical and dental coverage may be applied for by the Primary Member. The cost of coverage is the current COBRA rate. Such dependent is not eligible to be added under their parent's plan. There are no additional COBRA rights after attainment of age 30.

<u>Excluded Individuals for the Young Adult Option</u>:

1. Married dependents;

2. Dependents eligible for employer-sponsored coverage through their own employment;
3. Dependents covered by Medicare; and
4. Dependents that do not live, work, or reside in New York or the insurer's service area.
5. Continuation coverage ceases if a dependent ceases to meet the statute's definition of dependent. If a dependent falls out of the state's definition but later re-qualifies as a dependent, the dependent may again elect this option provided they enroll within 60-days of meeting the eligibility requirements. Otherwise, enrollment is only permitted during the annual open enrollment period.

Disabled Dependent Coverage after Age 26 Subject to Income Tax Rules Under §152

This test does not apply for purposes of health coverage prior to age 26; different rules apply for purposes of claiming an individual as a "dependent" on your income tax return. Both dependent statuses, for tax purposes and total and permanent disability status rules under the plan, are required after age 26 for health coverage. For a dependent to be claimed for tax purposes, they must meet all the following tests:

1. Must be a qualifying child, including an adopted child, or a qualifying relative.
2. Cannot be claimed as a dependent on any other tax return, including their own.
3. Must have the same principal place of abode as the taxpayer for more than one-half of the tax year.
4. Dependent has not provided over one half of his/her own support for the calendar year.

Relationship Test for purposes of a "Qualified Relative" or "Qualifying Child"

A Dependent is eligible for tax-exempt coverage under a welfare plan if the dependent meets the eligibility requirements under Code §152 and the dependent rules of this plan. In order to claim a "qualified child" or a "qualified relative" as a dependent for purposes of exempt medical care under this plan, they must bear a relationship to the taxpayer, which includes any of the following for purposes of this plan. A "Qualifying Relative" must also meet additional dependency and income requirements as provided below under §152:

1. Child or descendant of a child (of the taxpayer);
2. A brother, sister, stepbrother, or stepsister;
3. A son or daughter of a brother or sister of the taxpayer;
4. A brother or sister of the father or mother of the taxpayer;
5. An individual during the taxable year (other than a spouse), who has the same principal place of abode as the taxpayer and is a member of the taxpayer's household; or
6. §152 includes other qualifying relatives for tax purposes, such as dependent mother or father, etc. However, only a qualifying disabled child after age 26 may be covered as "dependent" subject to the plan's rules for disabled children after age 26.

Additional Requirements for a "Qualified Relative"

In addition to the "relationship test," a "qualifying relative" must also meet the following rules under §152 as well as any rules established for dependent coverage under the plan, including eligibility for Medicare coverage.

1. Have gross income less than the exemption as defined in §151(d) (currently $3,200);
2. Not be a "qualifying child;" and/or
3. The taxpayer (member) must provider over ½ of the support for any "qualifying relative."

Domestic Partner Coverage

Coverage of unmarried domestic partners terminated June 30, 2013. This plan no longer covers unmarried domestic partners. A domestic partner may be added following marriage in those states where marriage is legal. A partner must be added within 60-days of the event. Otherwise, they may only be added during open enrollment.

HIPAA NOTICE AND PRE-EXISTING CONDITION RULES

The KTF Plan Has No Pre-existing Condition Rules

You have full coverage under this plan as of the effective date of your enrollment. You must timely enroll by submitting an enrollment form. Go to www.ktftrustfund.com for access to important plan information, summaries, forms, and notices. For questions or assistance, contact the KTF Compliance Office at (844) 583-3863.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you can, in the future, enroll yourself or your dependents in the Plan, provided you request enrollment within 30-days *(or any extended period offered by the Plan)* after your other coverage ends.

Enrollment Permitted Mid-Year for Special Enrollment Situations

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you can enroll yourself and your dependents, provided you request enrollment within 30-days (or any extended period offered by the Plan) after the marriage, birth, adoption, or placement for adoption. *See special enrollment rules AND Qualified Life Event (QLE) Chart.*

Advance Written Notice Required for Certain Plan Changes

Written notification must be given to participants within 60-days of any material modifications to the Plan which eliminates benefits or reduces benefits payable under the plan, increase deductibles, copays, or other amounts to be paid by the participant or beneficiary, reduce the service area covered by an HMO, or establish new conditions or requirements to obtain services or benefits under the plan.

Portability of Your Coverage

HIPAA provides for portability and continuous coverage if there is not a break in continuous coverage as explained in Exhibit D. Any pre-existing period must be reduced by your prior period of continuous coverage. There are no pre-existing condition rules under this Plan. Your employer or insurer must automatically provide you with a Certificate of Coverage upon request or whenever your coverage is terminated; you then become entitled to COBRA, or when your COBRA coverage ceases.

Discrimination Due to Health Status Prohibited

HIPAA prohibits discrimination on account of health status. For further information about these laws, you can contact the Pension and Welfare Benefits Administration Publication Hotline at 1-800-998-7542 and ask for a copy of "Questions & Answers: RECENT CHANGES IN HEALTHCARE LAW".

HIPAA PRIVACY AND PATIENT'S RIGHTS POLICY

The Benefit Trust is responsible for the administration of the Plan on behalf of the members and all beneficiaries. This notice is to advise you of the personal information we have about you, where we get it, and how we protect the information.

We obtain essential information in order to secure coverage or potential coverage, such as group health, life, or disability coverage from the District. This includes personal information, such as your Social Security number, date of birth, date of hire, address, e-mail address, and pertinent health information. Your employer can provide this information, claims information provided by an insurer or third-party administrator for your plan or by you personally on an enrollment form.

As an agent and/or compliance officer, this information is used solely for administration and marketing purposes to help with overall benefits and insurance programs, or to assist you or your employer in procuring benefits. We can, as permitted by law, without your prior permission, provide personal information contained in our records or files to persons or organizations, such as:

1. Insurance or stop-loss carriers to support insurance transactions, your claims, or to procure insurance coverage on behalf of you or your employer, as part of an overall benefit package;
2. Claims manager and its staff responsible for payment of claims;
3. Case management or pre-certification staff retained to manage these functions, or to audit the payment of claims on behalf of the insurer or stop-loss carrier;
4. Businesses with a service agreement, includes PPO providers or Third-Party Administrators;
5. Regulatory or law-enforcement authorities, including state insurance commissions, IRS, DOL, and PWBA;
6. Any business retained to provide services directly or indirectly to the Plan employer;
7. Medical providers and representatives of another plan;
8. Information is provided on a "need to know" basis. When we share personal information, we do so under a standard of confidentiality, with a confidentiality agreement required by law, which requires individuals to conform to our standards and keep confidential any information that we provide on an individual or company. We have established physical, electronic, and procedural safeguards to protect your information. Your personal information will remain protected in accordance with our privacy practices, as outlined in this notice, even if you are no longer a member or participant under the Plan; and
9. We do not sell or pass on any employee or employer information to any other party. This information will only be used to provide benefits and services in connection with the Plan.

Member ID

For privacy purposes, your Social Security Number will not be used as your member ID on your card. You will be assigned a system-generated ID. You will need to use that number when contacting our offices. You may be asked for your Social Security Number or date of birth in order to verify we are speaking with the correct party.

Person in Charge of Privacy Policies

The Board of Trustees of the Benefit Trust are responsible for the HIPAA policies. The designated Plan representative for the Trust is the Chairman of the Board of Trustees or the Executive Director as appointed by the Board of Trustees.

Medical Release and Authorization

In order to be eligible for benefits, each covered member who is age 18 or older, including dependents, is required to sign an appropriate enrollment form that includes a medical release and authorization. A release is required for the Plan to obtain the information necessary from providers to determine medical necessity and entitlement to benefits. This information is also used to pre-certify benefits, institute case management (including certain disease state case management programs), pay claims, and determine eligibility for benefits. Additional releases may be required, as appropriate, for behavioral health treatment. You will also be required to sign a medical release from your providers, and you may be required to sign additional releases by the Plan in order to authorize specific Plan representatives to gain access to confidential medical information and other protected information (PHI) under HIPAA. Parents should have their children aged 18 and older sign a release, and a husband and wife may want a release to permit his/her partner to communicate with the Plan and providers about his/her partner's medical care and/or condition. Without a release and authorization on file, providers and the Plan are limited in what can be discussed or disclosed to parents and/or other family members about their condition.

Authorized Individuals

The individuals who routinely have access to, and who are responsible for administering your medical benefit program, include the following entities and/or their successors as business associates of KTF:

1. KTF PPO Staff;
2. Claims Supervisor and authorized staff, including KTF subcontractors;
3. KTF Compliance Office (to manage complaints, coordinate benefits and treatment with various providers and/or parties of interest, to ensure compliance with the Plan and Privacy Laws);
4. PPO Networks contracted by the Plan and their staff;
5. The Prescription Benefit Manager (PBM) in charge of monitoring Rx card prescriptions and mail-order drugs;
6. Stop-Loss Carriers and Underwriters (to underwrite stop-loss coverage of the Plan, pay certain benefits as provided by Stop-Loss Coverage, including their agents, brokers or agents, and brokers working on behalf of the Plan);
7. Trustees and Trust Staff have access to limited confidential information, on a need-to-know basis; and
8. KTF Claims Office, Pre-certification Firm, or the Compliance Office, with respect to sensitive medical information.

Operations (Healthcare Operations)

Healthcare operations include, but are not limited to, the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reducing healthcare costs, protocol development, case management and care coordination, disease management, contact healthcare providers and patients with information about treatment alternatives and related functions;
3. Rate provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
4. Underwriting, premium rating and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, ceding, securing, or placing a contract for

reinsurance of risk related to healthcare claims, including stop-loss insurance and excess-loss insurance;

5. Conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse-detection and compliance programs; or
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods, or coverage policies.

Business management and general administrative activities of the Plan, including, but not limited to:

1. Management activities related to the implementation of and compliance with HIPAA's administrative simplification requirements;
2. Customer service, includes the provision of data analyses for policyholders, plan sponsors, or other customers;
3. Resolution of internal grievances; and
4. Due diligence in connection with the sale or transfer of assets to a potential successor of interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

The Plan will use and disclose PHI as required by law and as permitted with authorization of the participant or beneficiary. With an authorization, the Plan can disclose PHI to the benefit plans or other separate plans of the employer. As a condition of participation in the Plan, medical authorization is required as part of the enrollment application. Additional authorization may be required from time to time. For purposes of this section, the employer (or trust) is the plan sponsor. The plan will disclose PHI to the Plan Sponsor, only as permitted under HIPAA. Otherwise, only summary information will be provided.

Patient Consent and Disclosure

Healthcare providers are required to obtain consent from the covered individual to disclose PHI for TPO purposes. Uses and disclosures of psychotherapy notes, PHI for marketing, and sales of PHI can only be made with the individual's authorization. Other covered entities (health plans and clearing houses) are not subject to a consent requirement. However, the Plan must provide a disclosure notice to Plan members with the opportunity to refuse disclosure of any healthcare information. A separate written authorization is required for any employee of the Plan Sponsor or Trust, other than specifically designated Plan representatives, to deal with protected health information, or "PHI." The Plan intends to use or disclose PHI for underwriting purposes. The Plan is prohibited from using or disclosing genetic information for those purposes.

PHI can be disclosed among authorized business associates for TPO purposes, otherwise, PHI information must be de-identified. There are restrictions on the flow of information to "non-covered" entities, in particular the employer or Plan Sponsor, to preclude the unauthorized use of this information. However, a group health plan, including any business associate of the Plan, IS PERMITTED to disclose **summary health information** to the plan sponsor, subject to the following:

1. The information is subject to the "minimum necessary standard;"
2. The information can be used to obtain bids for health insurance coverage, modify, or terminate the group health plan; or
3. The information summarizes claims history, expenses, and type of claims.

To maintain confidentiality of your health information, you should only disclose personal information to authorized parties. Often information is discussed with co-workers and friends and when you disclose this

information, you have made the information public knowledge and it may not have the protection it would otherwise have, due to your voluntary disclosure.

Plan Sponsor Obligations

The plan sponsor has certain duties in conjunction with the Plan's HIPAA Privacy rules and agrees to ensure that adequate separation will be maintained between the Plan and the Plan Sponsor. The Plan is considered a separate legal entity. In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

1. A Trustee who serves as the benefit manager; and/or
2. Staff designated by the benefits manager, in writing, as authorized to deal with PHI.

The individuals authorized by the Plan to have access to PHI agree to abide by the following:

1. Not use or further disclose PHI, other than as permitted or required by the plan document, or as required by law;
2. Ensure that any agents, including a subcontractor and NHAI, to whom the plan sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor, with respect to the PHI;
3. Not use or disclose PHI for employment-related actions and decisions, unless authorized by an individual;
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the plan sponsor, unless authorized by an individual;
5. Report to the Plan any PHI use or disclosure that is inconsistent with the use or disclosure provided, for which it becomes aware;
6. Make PHI available to an individual, per HIPAA access requirements;
7. Make PHI available for amendment and incorporate any amendments to PHI, per HIPAA;
8. Make available the information required to provide an account of a disclosure;
9. Make internal practices, books, or records, related to the use and disclosure of PHI received from the Plan, available to the Department of Health and Human Services Secretary, for the purpose of determining the Plan's compliance with HIPAA; and
10. If feasible, return or destroy all PHI received from the plan the plan sponsor maintains in any form. Copies of PHI will be retained when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further use and disclosure to the purpose that makes the return or destruction infeasible.
11. If a "breach" of an individual's unsecured PHI occurs, the individual must be notified.

Treatment, Payment, Operations (TPO) Activities Defined

Treatment: The provision, coordination, or management of healthcare-related services by one or more healthcare providers. This includes coordination with a third party, consultations between providers, and referrals to other providers.

Payment: Activities undertaken by a health plan to determine coverage, payment obligations, or activities undertaken by a healthcare provider or health plan, to obtain or provide reimbursement for healthcare.

Operations (Healthcare Operations): Activities directly related to the provision of healthcare or the processing of health information including internal quality, oversight review, credentialing and healthcare

provider evaluation, underwriting, insurance rating and other activities related to creation renewal, placement of a contract of health insurance, or health benefits.

Use and Disclosure of Protected Health Information (PHI)

The Plan will use protected health information (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to healthcare treatment, payment for healthcare and healthcare operations. Payment includes activities undertaken by the Plan to obtain premiums, determine or fulfill its responsibility for coverage, and provision of plan benefits that relate to an individual for whom healthcare is provided. These activities include, but are not limited to:

1. Determination of eligibility;
2. Coverage and cost-sharing amounts, (for example: cost of a benefit, plan maximums, and co-payments, as determined for an individual's claim);
3. Coordination of benefits;
4. Adjudication of health benefit claims (including appeals and other payment disputes);
5. Establish employee contributions;
6. Risk-adjusting amounts based on enrollee health status and demographic characteristics;
7. Billing, collection activities, and related healthcare data processing;
8. Claims management and related healthcare data processing (includes payment auditing, investigating, and resolving payment disputes, and response to participant inquiries about payments);
9. Obtain payment under a contract for reinsurance (including stop-loss and excess-loss insurance);
10. Medical necessity reviews, reviews of appropriateness of care, or justification of charges;
11. Utilization review, including pre-authorization, concurrent review, and retrospective review;
12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement. The following PHI may be disclosed for payment purposes: name, address, date of birth, Social Security number, payment history, account number, and name and address of the provider and/or health Plan;
13. Reimbursement to the Plan (such as subrogation, refunds from providers, Medicare, or other plans, etc.); and
14. Underwriting.

Where to File Complaints or Appeals

All complaints must be filed with the KTF Compliance Office. When calling about a complaint or issue, you should request to speak directly to the KTF Compliance Officer or Assistant Compliance Officer. Many issues can be resolved on an informal basis. It is important for members and providers to understand that if an appeal is not resolved on an informational basis within 30-days, they should always file a formal written appeal in order to protect their appeal rights under the plan. *(Please see Important Contact Information in Part A for contact information.)*

INITIAL COBRA NOTICE (CONTINUING COVERAGE RULES)

The KTF Compliance Office administers COBRA Continuation Coverage. All checks, questions or communications concerning COBRA are to be directed to the COBRA Administrator.

COBRA Administrator: KTF Compliance Office
416 Creekstone Ridge
Woodstock, GA 30188
Phone: (844) 583-3863
Fax: (770) 874-1097

You are receiving this Notice because you have recently become covered under the above Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. COBRA continuation coverage was created The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This notice is a summary of your COBRA continuation coverage rights.

COBRA continuation coverage is a continuation of coverage when coverage would otherwise end due to a "qualifying event." Specific qualifying events are listed below. COBRA continuation coverage must be offered 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. Depending on the type of qualifying event, an employee, a spouse or dependent of an employee, may be a qualified beneficiary.

Qualified Beneficiary and Qualifying Events

A qualified beneficiary has independent COBRA rights. Any spouse or dependent acquiring coverage after the initial qualifying event, as a result of an open enrollment or special enrollment election is not considered a qualified beneficiary and their coverage ends whenever the qualified beneficiary's coverage ends. Your status as a qualified beneficiary and your right to continue coverage will be based on the reason for the COBRA event, as explained below. The coverage termination date will be based on the terms of the Collective Bargaining Agreement and in accordance with the Plan rules, including the new rescission of coverage rules under the Affordable Care Act.

Effective July 1, 2010, the initial COBRA period for any Qualifying COBRA event is 36 months for any Qualified Beneficiary. As a self-funded Plan, the Plan voluntarily adopted the New York State COBRA rules. This plan shall automatically incorporate by reference any rules regarding any federal COBRA subsidy for employees who involuntarily lose their coverage.

1. If you are an employee, you become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:
    a. Your hours of employment are reduced; or
    b. Your employment ends for any reason other than gross misconduct.
2. If you are the spouse of an employee, you become a qualified beneficiary if you lose your coverage with the Plan because of any of the following qualifying events:
    a. Your spouse dies;
    b. Your spouse's hours of employment are reduced;
    c. Your spouse's employment ends for any reason other than gross misconduct;
    d. Your spouse enrolls in Medicare (this only applies to qualified beneficiaries if this results in actual "loss" of coverage at the time of the initial qualifying event); or
    e. You become divorced or legally separated from your spouse.

3. Your dependent children will become qualified beneficiaries if they lose coverage with the Plan because of any of the following qualifying events:
    a. The parent-employee dies;
    b. The parent-employee's hours of employment are reduced; or
    c. The parent-employee's employment ends for any reason other than his/her gross misconduct.
    d. The parent-employee enrolls in Medicare (refer to Part A, Part B, or both):
    e. The parents become divorced or legally separated; or
    f. The dependent child stops being eligible for coverage under the Plan as a "dependent child".

Sometimes filing a bankruptcy proceeding under Title 11 of the United States Code can be a qualifying event. If a bankruptcy proceeding is filed with respect to the Plan or the district, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also be qualified beneficiaries, if bankruptcy results in the loss of their coverage with the Plan.

The Plan will offer COBRA continuation coverage to "qualified beneficiaries" only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a bankruptcy proceeding with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

The law defines a **Qualified Beneficiary** as an individual covered under a group health or dental Plan on the **day before the event causing loss of coverage** (termination of employment, a divorce, or death of a covered employee).

Member Responsibility (and Consequences for Failure) to Notify Plan of Status Changes

You must notify the Plan Administrator for other qualifying events (divorce or legal separation of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child by becoming of age or no longer a full-time student). **The Plan and COBRA rules require you to notify the Plan Administrator within 60-days after the qualifying event occurs.**

In order to protect your family's rights, you must keep the Plan Administrator informed of any changes in the mailing address, phone numbers and email addresses of family members. Keep a copy for your records of any notices you send to the Plan Administrator.

If you fail to timely notify the Plan in writing, using designated change forms provided by the Plan, the Plan cannot be responsible for delayed delivery or non-delivery of any notices due to mail sent to the wrong address of record. The following consequences will apply:

1. You will be personally liable to reimburse the Plan for the lesser of the actual COBRA cost of coverage (under COBRA rules) or the actual benefits paid after the initial qualifying event;
2. Extended COBRA benefits are not available if a Notice of a Second Qualifying Event is not timely received; or
3. COBRA rights are forfeited if you fail to notify the Plan within 60-days of any change requiring a notice from you, the member.

COBRA Election Notice and Cost of COBRA Coverage

Once the Plan Administrator receives a notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin as of the later of:

1. The date of the qualifying event; or
2. The date Plan coverage would otherwise end as noted on your COBRA Election Form. Coverage generally ends as of the last day of the month during which the COBRA event occurs. *See Termination of Coverage in Part A, Eligibility and Dependent Coverage Rules.*

Qualified Beneficiaries pay the entire cost of coverage, which is 102% of the actual cost of the coverage. COBRA Costs are adjusted each January 1, as of January 1, 2013, based on actual costs for the prior year.

Special Rules for Medicare

For Medicare coverage to be a qualifying COBRA event, Medicare coverage must result in the actual loss of coverage under the Plan. Generally, due to the Medicare Secondary Payor rules, eligibility for Medicare does not result in a "loss of coverage." Medicare simply is considered "secondary" coverage if the employee remains actively employed unless the employee chooses to make Medicare his/her primary coverage. It is illegal under Medicare rules to encourage or provide any incentive for employees to do this. (Revenue Ruling 2004-22) If Medicare is acquired during COBRA coverage, after the initial qualifying event, this is not considered a COBRA event if Medicare coverage would not have automatically resulted in the loss of coverage while actively employed. Such a provision would violate the Secondary Medicare Payor rules for any Plan covering 20 or more employees.

<u>Example</u>: If an actively employed member drops group health for a spouse during open enrollment, this is not considered a COBRA event. If spousal coverage is dropped due to legal separation or divorce, it is a COBRA event.

Special Plan Rules for Certain Divorced Individuals and Retirees

The following special rules apply to <u>retiree coverage</u> and changes in coverage after retirement:

1. Upon the death of a retiree's spouse, if the employee remarries, he/she can add his/her new spouse and any dependents within 60-days of the date of acquiring new dependents. Otherwise, new dependents can be added only during any open enrollment or due to a Special Enrollment situation;
2. In the event of divorce, the former spouse can only continue coverage under COBRA. A retiree can add a new spouse or dependents after retirement;
3. Upon the death of a retiree, the retiree's spouse's coverage will end at the end of 90-days following the month during which death occurs. Coverage can be continued following the death of a retired employee under COBRA, subject to COBRA rules. *See extended COBRA coverage below;* or
4. <u>Adding a dependent/spouse at the time of retirement</u>: If a retiree has single coverage, a spouse or dependent coverage can be added within 30-days the new dependent was acquired. Otherwise, a new dependent can be added only during any open enrollment or due to a Special Enrollment.

Extended COBRA Coverage for Widows/Widowers of Retirees after Initial 36 Months

<u>The following special rules apply to retiree coverage and changes in coverage after retirement</u>. The initial COBRA period may be extended, subject to COBRA's premium payment and lapse of coverage rules. This provision is subject to change in the event this Plan is amended, terminated, or discontinued.

1. A widowed spouse of a retired member: The spouse can continue COBRA coverage at COBRA rates for his/her lifetime following the death of a retired member only. If the spouse remarries, additional dependents or a new spouse may not be added after the initial COBRA period.
2. During the initial 36 months of COBRA coverage, a new spouse or dependents can be added as a dependent provided the member pays the additional cost. Extended coverage for a dependent not covered at the time of the initial COBRA event (death or divorce) is not eligible for extended COBRA coverage after 36 months. Please refer to the Retiree Manual and other information about your Medicare options online at www.ktftrustfund.com or call the KTF Compliance Office.
3. Divorced Spouse of a Retiree Aged 55 or Older: May elect extended COBRA coverage if they were married to the Primary Member/Retiree and covered under this Plan for five (5) years or more prior to the death of the retired member.

A widow or widower should carefully consider their options:

1. If you are also entitled to Retiree Coverage by reason of your own former employment, it may be more cost effective to elect that coverage.
2. You are required to enroll in Medicare when you are first eligible by reason of age or disability.
3. You may want to consider electing alternate coverage such as a Medicare Supplement Plan or Medigap Plan along with a Medicare Part D Plan, or a Medicare Advantage Plan with Prescription Drugs (MAPD) plan. Go to www.medicare.gov for additional information.

For questions about your COBRA continuation coverage, Medicare options, contact the KTF Compliance Office at (844) 583-3863.

MEDICAL NECESSITY POLICY AND NOTICE

Medical Necessity Defined

All benefits except for specific preventive/wellness benefits are subject to medical necessity and will be limited to the level (frequency, extent, setting, kind) of medical or behavioral services and supplies necessary to adequately diagnose and treat an illness or injury (including maternity care or emergency care, behavioral, mental health, or addiction treatment), according to standard medical practice. Appropriateness of care is also considered. The treatment must be consistent with the diagnosis and recognized standards for the treatment of the specific condition.

Any item that is primarily for the convenience of the patient or the healthcare professional(s) involved is not considered medically necessary (such as: cosmetic surgery, personal care items or physical exams at the request of an employer, school, court, or government agency). Charges for missed appointments are not covered since no service has been provided. It is the patient's sole responsibility to show up for scheduled appointments or to cancel appointments timely, per the provider's policy.

The fact that one of our covered physicians, hospitals, or other professional or facility providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

The level of care criteria that follows the guidelines for determining medically necessary treatment based on DSMIV-TR disorders. Services by a provider to identify or treat an illness that has been diagnosed or suspected and consistent with:

1. The diagnosis and treatment of a condition;
2. The standards of good medical practice required for other than convenience; and/or
3. The most appropriate (supply) or level of care.

Clinical services for reasons other than medical necessity, e.g., to comply with a court order, obtain shelter, deter anti-social behavior, deter truancy or runaway behavior, or achieve family respite, do not necessarily determine a "medical necessity" decision. Coverage for services is subject to plan limitations, plan design, and should adhere to information that dictates which medically necessary criterion is applicable.

The following office visits are subject to medical necessity review, including:

1. Any chiropractic or acupuncture treatment in excess of 6 visits.
2. All physical or other therapy (including cardiac rehab) requires pre-certification.
3. Pain management treatment in excess of 6 visits.
4. Medical office visits in excess of 6 with any provider.

Pre-certification Principles

All inpatient stays are based on admission criteria, severity of need and intensity of service and must be pre-certified prior to admission, except in the case of an emergency. Length of stay will be characterized by continued stay criteria. *See guidelines below, including guidelines for inpatient detoxification.*

When a patient has a psychiatric disorder that requires professional evaluation, intervention, and treatment, he/she should be treated at the least intensive outpatient level appropriate for the condition prior to partial Hospital/ day treatment, unless there is compelling evidence to the contrary. Pre-certification must be obtained by contacting the Pre-certification Department at (844) 583-3863, Ext 3.

- Pre-certification is required for all inpatient and intensive outpatient treatment in advance of treatment.
- Emergency care must be pre-certified within 24 hours or the first working day following a weekend admission.
- All outpatient care in excess of six (6) visits must be pre-certified prior to treatment.
- Penalties apply and benefits will be reduced for failure to pre-certify benefits as required by the Plan.
- Benefits for behavioral health and pre-certification rules are the same as for medical benefits under the Mental Health Parity rules.

Emergency or Life-Threatening Condition Requiring Emergency Care

Any accident or illness that requires immediate treatment to relieve the sudden onset of severe pain, fever, swelling, serious bleeding or severe discomfort and to the extent that treatment cannot be delayed until the following day during normal business hours where treatment can be rendered by your own physician or at an urgent care center. Additional cost sharing applies for emergency room treatment for non-emergency situations.

Experimental, Investigative Services or Supplies Are Not Covered

Any treatment, surgery, procedure, facility, equipment, drugs, drug usage, devices or supplies not recognized as accepted medical practice or not recognized by the Health Plan, at its sole discretion, except for any treatment that is deemed appropriate by an Independent Review Organization (IRO) in accordance with the appeal procedures required under Health Care Reform and the Plan. Also included is any medical supply or service that requires the government's approval that has not been granted at the time the service or supply was provided. Prescriptions, treatment, and devices prescribed by physicians beyond the labeled usage or general usage may be covered by the Plan if, in the sole discretion of the Plan, the service or supply is medically necessary, cost effective and considered to be a viable alternative treatment for a serious or chronic condition. *See "Clinical Trials."*

Clinical Trials

A covered member participating in an Approved Clinical Trial as defined by PPACA §2709 shall be covered for items and services that would be typically covered for a member who was not participating in a clinical trial in accordance with §2709 of the PPACA and any rules issued with respect to that section only after those provisions become effective for this Plan.

Behavioral and Addictive Treatment – Medical Necessity Criteria

Levels of Care for Substance Abuse

The following guidelines are based on the ASAM placement criteria for the treatment of Substance Abuse Related Disorders, 2nd Edition-Revised, David M. Lee, M.D. Editor, 2001.

Hospitalization – Inpatient: Care that can only be administered on an inpatient basis. Hospitalization is considered the highest level of care that can only be obtained by providing skilled Psychiatric and or substance abuse services in a hospital or residential treatment facility. This includes both "free standing" and "General" hospital settings that provide detoxification and psychiatric services and are licensed by the state to provide 24-hour medical and nursing care.

This also includes "crisis" bed or "23-hour" bed. This level of care is defined as a 24-hour level of care that provides patients diagnosed with a mental health disorder which cannot be treated at a lesser intensive level of care. Licenses for this level of care may vary by state (commonly accepted is CARF & JCAHO accreditation).

Subacute Hospitalization – Psychiatric: This level of care is designed to meet the needs of patients with mental health problems that require an inpatient setting due to potential harm to self or others but do not represent an imminent threat to themselves or others. This level of care serves patients who require a "less intensive" setting than an acute care or hospital level setting, but more intensive than a residential type of setting. This level requires 24-hour monitoring and supervision in addition to a safe and effective treatment environment. Treatment includes daily psychiatric nursing evaluation and intervention. This level of care requires that the patient be seen by a psychiatrist at least 3 times weekly for medication management and psychotherapy. Whenever possible, family involvement should be an integral part of the treatment process.

23 Hour Observation: 23-hour observation is used to evaluate and stabilize patients who present in a crisis situation. This level of care occurs in a secure and protected environment and is staffed with both medical and clinical personnel, psychiatric supervision and 24-hour nursing. Observation should be used to establish the appropriate level of care, be it admission to an inpatient setting or a referral to outpatient follow up care.

Based on a patient's potential risk to self or others; (suicidal or homicidal ideation) a patient may require observation to diagnose, clarify or assess psychiatric needs; or a patient may need a "crisis intervention."

Presence of illness or illnesses when there is more than one diagnosis must be documented under the DSM-IV-TR codes on all Axes (I-V). There may be a lack of a primary diagnosis based on the symptoms a patient may be exhibiting; (e.g., intoxication) where a primary diagnosis cannot be determined and only through an extended period of time can the patient be appropriately and clinically assessed. Under 23-hour observation, a comprehensive assessment is usually done by a psychiatrist and includes a biopsychosocial, based on information available at that time.

A physical exam is usually performed along with the patient's history for possible sexual, physical, or emotional abuse along with laboratory testing and toxicology to determine other possible medical conditions. Medication may be administered during observation and the patient must be medically stable before discharge.

If the patient cannot be stabilized during this time, a referral to inpatient psychiatric treatment is made by the attending psychiatrist and/or clinical team.

Partial Hospitalization-Psychiatric: These programs are defined as having the capacity for planned, structured services of at least 6 hours per day and at least 4 times per week. The range of services at this level of care should include; individual, group, family, and multifamily psychotherapy, as well as medication management.

Intensive Outpatient-Psychiatric: Intensive Outpatient programs are defined as structured outpatient services of at least 3 hours per day and 3 days per week. These services are designed to address both mental health (and substance abuse) related disorders. They include Group, Individual, Family, Multifamily groups, psychotherapy, and psycho educational services and may also include medication management.

Outpatient Treatment-Psychiatric: Outpatient treatment is defined as individual, family and/or group psychotherapy in addition to medication management by a licensed Psychiatrist, Psychiatric Nurse Practitioner, Ph.D., Ed.D., LPC, LCSW, LMFC, and LMHC. The goal of therapy in the above-mentioned outpatient settings (Partial Hospitalization, Intensive Outpatient, or traditional Outpatient therapy) is considered the restoration to the level of functioning exhibited prior to the onset of the illness.

For those with long term chronic conditions, the goal is "control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization."

Psychiatric Hospital Admission Criteria

At least three of the following must be met in order to satisfy the criteria for "Severity of Need":

1. The patient has a diagnosed or suspected mental illness. Mental illness is defined as a psychiatric disorder that by acceptable medical standards, can be expected to improve significantly via medically necessary procedures and appropriate therapy at a level of care that cannot be met by any other means except that of a hospitalization admission.
2. Presence of illness or illnesses can be documented based on DSM-IV-TR codes and criteria on all applicable Axes I-V.
3. Patient verbally or actively demonstrates serious harm to self or others. Patient verbalizes a current plan or intent to harm self or others; has exhibited a recent attempt to harm self or others; or exhibits a continued risk as demonstrated by poor impulse control, disorganized thoughts, or bizarre behavior.
4. Patient's condition requires an acute psychiatric intervention or assessment that can only be provided in an inpatient setting and could result in a dangerous deterioration of the patient's mental health.

Continued Stay Criteria

1. Despite all reasonable therapeutic efforts, the admitting diagnosis continues to meet inpatient criteria; the patient continues to exhibit symptoms that indicate he/she is not "medically stable" for discharge or cannot be "medically cleared" by the attending Physician or Psychiatrist.
2. The patient has had a severe negative reaction to prescribed medication.
3. Discharge would result in the intensity of symptoms to the degree that would result in continued hospitalization.
4. The patient cannot contract for safety or discharge planning back to patient's environment is "clinically" inappropriate.
5. Daily progress notes documenting the provider's treatment and the patient's response to treatment.

Inpatient Electroconvulsive Treatment Authorization Criteria

A clinical assessment or evaluation indicates the patient has a DSM-IV-TR Axis I diagnosis under acceptable medical standards and is expected to improve significantly only by means of appropriate ECT.

Diagnoses should include the following: (and those that have not responded to traditional appropriate medication management) major depression, mood disorder with psychotic features, specific types of bipolar disorder, schizoaffective disorder, schizophrenia, catatonia, psychosis, acute mania, sever lethargy associated with a psychiatric condition and other psychiatric disorders or syndromes associated with medical disorders.

1. The patient refuses to comply with or tolerate side effects of previously administered medications or has a co-morbid medical condition that averts the use of available medications.
2. The patient is pregnant and severely depressed and the risks of ECT treatment outweigh the risk of providing no treatment.
3. The patient has a history of previous ECT treatment that was successful in treating the disorder.
4. The severity and type of symptoms have become so debilitating, that only an emergency response such as ECT becomes the only available course of treatment.

Psychiatric Partial Hospitalization Criteria

Medical Necessity is based on the definition above. Documentation from the hospital's clinical team which indicates that despite treatment efforts or there is an appearance of additional problems consistent with the admitting diagnosis.

Any attempt at re-entry to a lesser level of care is clinically inappropriate or could exacerbate the current symptoms whereby the patient would need another inpatient hospital admission.

(Child and Adolescent Treatment for above levels of care dictate the same medical necessity and intensity of treatment.) Family members must be actively involved in all aspects of treatment before appropriate discharge and or disposition recommendations are developed.

Psychiatric Intensive Outpatient Criteria

A face-to-face clinical evaluation should always be performed prior to admission to any Intensive Outpatient program. The patient must have a primary DSM-IV-TR diagnosis that is the result of significant psychological or social impairment.

The patient's disorder is expected to improve considerably through medically necessary treatment, and the individual is "behaviorally" stable and "cognitively" stable to benefit from an Intensive Outpatient program. For those individuals with an acute or persistent disorder, or those transitioning from an inpatient setting, there must be clinical evidence that a "less intensive" level of care is insufficient to prevent a decline in symptoms, stabilize the patient or prevent the necessity of a more intensive level of care.

Traditional Outpatient Psychotherapy Criteria

1. The patient has been evaluated for a DSM-IV-TR diagnosis on Axes (I-V).
2. The patient presents with a behavioral, psychological and/or biological dysfunction and/or functional impairment which is consistent with a psychiatric disorder on Axis I or Axis II of the DSM-IV-TR.
3. The patient has mild symptomatic distress, impaired functioning resulting from psychiatric symptoms associated with the DSM-IV-TR.
4. The patient has a history of repeated psychiatric admissions to residential treatment or has a history of a chronic psychiatric disorder.
5. The patient does not require a higher level of care.

Substance Abuse/Dependency

Criteria for all substance abuse/dependence are based on the severity of need as indicated in the first 6 dimensions of ASAM (The American Society of Addiction Medicine) criteria.

Detoxification in a General Hospital

The following meets medically necessary criteria for an acute inpatient detoxification:

1. Co-morbid conditions are present and withdrawal under any other circumstance could result in a life-threatening situation.
2. The patient has a history of seizures, tremors, delirium, or any other medical condition (e.g., uncontrollable Diabetes) which would result in serious harm to the patient.
3. A "free standing" facility is not medically equipped or medically staffed to the extent where a safe detoxification can be facilitated.

Inpatient Detox/Rehab Admission Criteria (Free Standing Facility)

The following definitions must be met in order facilitate an inpatient admission for Substance Abuse to a freestanding facility:

1. The patient has a recent history of heavy and continuous use of substances, whereby withdrawal from the substance is life threatening or can cause serious physical harm; or is so uncomfortable and disruptive that any other level of care is clinically inappropriate; clinically sound or is clinically recommended by a referring physician, outpatient setting, or any other qualified addiction professional licensed by the state.
2. Detoxification cannot be safely managed at a less intensive level of care.
3. The patient has failed to maintain sobriety in an outpatient setting for a period of no less than 3-4 weeks.
4. The patient is presently experiencing symptoms of withdrawal but does not meet criteria for an acute "hospital based" detoxification.
5. A valid support system or less intensive level of services cannot meet the patient's clinical needs.
6. The patient is at significant risk of severe withdrawal symptoms or has had seizures based on previous withdrawal history.

Continued Stay Criteria

The following criteria are reviewed with your provider to establish the medical necessity of your continued stay:

1. The patient exhibits physical illnesses other than withdrawal that need to be addressed or may complicate treatment.
2. The patient has chronic conditions that affect treatment.
3. The patient has a psychiatric, psychological, behavioral, emotional, or cognitive problem that needs to be addressed because they create risk or complicate treatment.
4. The above-mentioned problems appear to be part of the addictive disorder.
5. The patient cannot manage daily activities due to ongoing use of substances.
6. The patient exhibits a willingness to change their addictive behavior.
7. The patient is compliant with all aspects of the treatment program and is aware of the negative consequences of substance abuse and is willing to change his/her behavior.
8. The patient is in immediate danger of continued severe mental health distress and/or alcohol or drug use.
9. The patient's problems are severe enough to cause such distress that relapse is inevitable unless he/she is engaged in continued inpatient treatment at this time.
10. The patient has successfully exhibited ways to cope with cravings, impulses, and relapse triggers.
11. The patient has a safe and non-toxic environment to return to that will not pose a threat to the patient's safety (Includes financial, educational, and vocational resources).
12. The patient has a viable outside support system in place (whenever possible includes family members).
13. Transportation, childcare, housing, or employment issues are clarified or addressed prior to patient's discharge.
14. An "aftercare" or next level of treatment appointment with an outpatient agency has been obtained within 72 hours prior to discharge.

Intensive Outpatient

Intensive Outpatient should consist of 2-3 hours per day, three times per week of rehabilitation counseling through groups, individual, didactic and/or family counseling.

Intensive Outpatient Counseling Substance Abuse/Dependent Criteria

1. A clinical evaluation indicates that the patient has a primary DSM-IV-TR diagnosis or diagnoses of substance abuse/dependency and is cognitively stable enough to benefit from admission to an intensive outpatient program.
2. A traditional outpatient setting cannot provide appropriate therapeutic services necessary for recovery and a more intensive level is required for the patient to maintain abstinence.
3. Patient does not clinically require or meet criteria for detoxification or residential treatment; and/or the patient's history reflects an inability to maintain abstinence over a consistent period of time.
4. The patient has an appropriate support system in place and exhibits skills to manage cravings, make behavioral changes and is medically compliant.

Methadone Maintenance

There is "no coverage" for Methadone Maintenance under the plan. Any covered individual who chooses to be maintained on Methadone will be held solely financially responsible for these services.

Excluded (Not Covered) Mental Health or Addiction Treatment

This plan does not cover the following treatment. However, the Plan reserves the right, in its sole judgment, to approve alternative treatment programs if it determines that the program is appropriate for the individual case, based on all facts and circumstances, and is comparable to other programs in terms of overall cost to the Plan. Such programs may be paid either as a PPO program pursuant to an individual case agreement or a NPPO program.

1. **Court Ordered Treatment**: Any treatment (inpatient or outpatient) ordered by a local, state, or federal court will not be covered. Treatment undertaken in order to *avoid or reduce* any legal judgment or penalty that would otherwise apply as a result of an illegal act is not covered.
2. **Chronic conditions** that cannot be favorably changed by a specific treatment plan are not covered as such care is not considered medically necessary once no additional improvement is expected. *See also Long-Term Care below.*
3. **Custodial or Long Term Care:** Long term care is considered "custodial" care and is not covered for medical or any behavioral, psychological or addictive condition, including acute cases of autism, bi-polar, Asperger syndrome and other mental health or addiction conditions once maximum medical or mental health stability or psychological improvement is made and there is no expectation that continued treatment will favorably change the patient's condition. Any training or institutional care, including specialized schools for the treatment of any medical, mental health or behavioral condition is not covered under this plan.
4. **Disabled dependents who are Medicare eligible** are not eligible for continued coverage after age 26. Any dependent coverage for a disabled dependent after age 26 is subject to the dependency rules of the plan and timely application for disability status. Members are required to apply for Social Security Disability and/or Medicare on behalf of a disabled dependent when they are eligible. A copy of the acceptance or denial of disability coverage is required by the plan after age 26 for continued disability coverage. Verification of Medicare coverage is also required.

5. **Educational Services and/or Treatment:** Educational services for the treatment of medical, behavioral, or learning disorders, behavioral training and cognitive rehabilitation are not covered. Special schools for learning disabilities or other disabilities are not covered by this Plan. *See Custodial or Long-Term Care above.*
6. **Experimental treatment or clinical studies not approved in writing:** Any experimental treatment or clinical study must be approved in advance of treatment by the Plan or on appeal by a peer reviewer or external review process.
7. **Failure to Complete Treatment Program:** Penalties for failure to complete any medical, behavioral or addiction treatment program or to complete a treatment program following detoxification – benefits will be reduced as provided in Part A.
8. **Failure to Pre-certify Care:** Any care that is not pre-certified in accordance with plan rules is subject to Plan penalties and may not be covered unless retrospectively pre-certified. All inpatient treatment or extensive outpatient program, as well as any therapy visits in excess of six (6) visits must be pre-certified.
9. **Half-way houses or group homes:** Any shelter or facility that is not appropriately licensed as a medical facility with appropriate medical staffing and managed by a physician or psychiatrist and approved by the Plan is not covered under this plan.
10. **Ineligible Members:** Services when you are not an eligible member of the plan by reason of age (dependent) or by relationship (spouse or domestic partner) are not covered unless COBRA premiums are paid for the period beyond the date when the coverage terminated due to a change in family status.
11. **Long Term Care:** see custodial care.
12. **Unaccredited Facility:** Care provided by a facility not appropriately accredited as a hospital, skilled nursing facility, or behavioral health or addiction treatment facility are not covered unless approved by the Plan. Any specialized treatment program must be approved in advance.

2022 MEDICARE CREDITABLE RX COVERAGE NOTICE

Rx Coverage for Medicare Members

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the above plan and about your options under Medicare's prescription drug coverage once you are Medicare Eligible **(first day of the month in which you attain age 65 or first day of the 25th month following your eligibility for Social Security Disability benefits).** This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

KTF's Prescription Drug Plan is considered "creditable coverage." It is, on average, at least as good as standard Medicare prescription drug coverage. You can keep your KTF Rx coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

KTF Does Not Coordinate Rx Coverage – Only One Rx Plan is permitted: If you join a Medicare drug plan, your KTF Rx coverage will be suspended, and you and your dependents may not get this coverage back until the Medicare Part D coverage is terminated. Generally, Part D coverage may only be terminated during the Open Enrollment Period (10/15 to 12/7) with an effective date of the following January 1.

Enrollment in Medicare Part A and B is Required: You are required, under the KTF Plan, to be enrolled in both Medicare Part A and B when you or a covered spouse or dependent no longer has coverage as an employee or dependent under an active employee and is eligible for Medicare. The KTF Plan provides comparable Rx coverage; therefore, whether you enroll in Medicare Part D is up to you.

Diabetics Must Get their Diabetic Supplies through Medicare Part B: Medicare Primary Members must get their diabetic supplies through Medicare Part B and then submit the claims to KTF to reimburse any balance not covered by Medicare.

Medicare Part D Prescription Drugs Coverage: Anyone who is eligible for Medicare Part A and/or has Medicare Part B can get Medicare Part D Prescription Drug coverage. You get Medicare Part D Drug Coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Open Enrollment for Medicare and Medicare Part D coverage: October 15 to December 7

Penalty for Failure to Have Creditable Rx Coverage: If you go 63 continuous days or longer without "creditable" prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. If you lose creditable prescription drug coverage, through no fault of your own, while currently enrolled in any MA, MAPD or PDP plan or enrolled in original Medicare and meet eligibility requirements for Medicare Advantage, you will be eligible for a Special Enrollment Period (SEP) allowing you to switch to a 5-star plan at any point during the year.

If you lose or decide to leave employer/union sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. A surviving spouse of a deceased retired member has the option of continuing their retiree coverage under COBRA rules or electing Medicare coverage if they are Medicare eligible. They may also have a guaranteed issue opportunity for enrollment in a Medigap plan in lieu of continuing their coverage with KTF. All options should be compared carefully.

The Part D Late Enrollment Penalty: is 1% for each month you did not have "creditable coverage".

Special Rules apply for Nursing Home Residents:

1. **<u>Medicaid Residents</u>**: If a member qualifies for Medicaid and is in a nursing home, the facility and Medicaid may automatically enroll the member in Medicare Part D and there may be additional subsidies for Medicare copays and deductibles for special needs patients. ***See the Prescription Schedule of Benefits found in Part A of your Plan.*** Medicaid eligible members are permitted to change their Medicare coverage at any time. *(See Help with Medicare Costs below.)*
2. **<u>Private Pay Residents</u>**: If the nursing home requires prescriptions be dispensed by a special pharmacy in blister packs, please contact the KTF Compliance Department at (844) 583-3863 for an override that will permit the nursing home to fill the prescriptions locally rather than through mail order.

The basic Medicare Part D Drug Program works as follows. The Medicare deductible and threshold limits are adjusted annually for cost of living. The current Notice of Creditable Coverage will be posted on the KTF web site at www.ktftrustfund.com.

Standard Medicare Part D Benefits		
	2021	**2022**
Part D Annual Enrollment - Open enrollment from 1/1 to 3/31 was eliminated. Members are only permitted 1 change to their Medicare Advantage and/or Part D Plan 1/1 to 2/14.	10/15 to 12/7	10/15 to 12/7
Medicaid Eligible Individuals *(See Resources Limits for Financial Assistance below.)*	May change their Medicare Enrollment at any time.	
Deductible – Employee pays 100% of Deductible	$445	$480
Initial Coverage Limit - Employee Pays 25% of the Cost of the Drugs	$4,130	$4,430
Out-of-Pocket Threshold - Employee pays 25% of the cost of drugs during the GAP Period until the OOP is met. **In 2021**, there will be a 75% plan benefit (25% retiree-paid coinsurance) for generic and brand drugs. The 25% coinsurance counts against the OOP threshold.	$6,550	$7,050
Total Covered Part D Drug Spending (total cost of drugs including your portion of the cost) before Catastrophic Coverage	$9,313.75	$10,012.50
Minimum copays for Catastrophic coverage	$3.70 generics $9.20 brand or 5% of the cost	$3.95 generics $9.85 brand or 5% of the cost
Resource Limits For Financial Assistance: Eligible for QMB/SLMB/QI, SSI or applied and income at or below 135% FPL and **resources ≤ $14,790 (individuals) or ≤ $29,520 (couples).**		

Help with Medicare Prescription Drug Plan Costs: Low Income Subsidy

If you or a covered dependent or spouse qualify for low-income subsidy, are covered by Medicaid or in a nursing home, this may be better Rx coverage than the KTF Prescription Plan due to the Medicaid subsidies. Please notify the Plan if a covered member is in a nursing home. You must request an override for drugs to be covered by a pharmacy who supplies the patient's medications in blister packs to the nursing home.

Some people with limited income and resources are eligible for Extra Help to pay for the costs—monthly premiums, annual deductibles, and prescription co-payments—related to a Medicare prescription drug plan.

The Extra Help is estimated to be worth an average of $3,900 per year. Many people qualify for these savings and do not even know it. **To find out if you qualify, Social Security will need to know your income and the value of your savings, investments, and real estate (other than your home). If you are married and living with your spouse, we will need information about both of you.** ***See Resource Limits for Financial Assistance in the above table.***

1. You must have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance).
2. You must live in one of the 50 states or the District of Columbia.

The 2022 Federal Poverty Level (FPL) Guidelines determine the income level requirements for people applying for the Low-Income Subsidy (LIS) program. If your income is below 135% of the FPL ($17,388 if you are single or $23,517 for married couples), you could qualify for the full Low-Income Subsidy – *see resource limits above*. If you do not qualify for full LIS benefits, you could be eligible for partial LIS benefits if your income level is at or below 150% FPL. LIS subsidy helps to pay both your monthly plan premiums and drug costs.

For more information about getting extra help with your Medicare prescription drug plan, visit **www.socialsecurity.gov** or call Social Security at **1-800-772-1213** (TTY **1-800-325-0778**). Social Security representatives are available to help you complete your application.

For more information about this notice or your current prescription drug coverage: Contact the person listed below for further information. **NOTE:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan (each October 15 to December 7 is open enrollment). You may also request a copy. *See Part A for you Prescription Drug Schedule of Benefits*.

1. For more information about your options under Medicare prescription drug coverage:
2. Order or download the ***"Medicare & You"*** handbook. You will receive a copy of the handbook in the mail every year from Medicare.
3. Visit www.medicare.gov.
4. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the **"Medicare & You"** handbook for the telephone number) for personalized help.
5. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and whether you are required to pay a higher premium (a penalty).

Also, *see Notice on Medicare Enrollment* – KTF Requires Part A and B coverage when no longer covered as an active employee or dependent of an active employee who is the Primary Insured for your dependent coverage.

Please provide the KTF Compliance Office with a copy of your Medical Power of Attorney or a HIPAA Authorization if you wish to authorize KTF to deal directly with another party on your behalf regarding claims, coverage, eligibility and/or billings. If you are paying premiums for your coverage, please provide an alternate contact in the event you are unable to manage your affairs due to an accident or medical condition.

Updated: October 1, 2021
Name of Entity/Sender: Kingston Trust Fund

Contact: KTF Compliance Office
Address: 416 Creekstone Ridge
Woodstock, GA 30188
Phone: (844) 583-3863

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

The Newborns' and Mothers' Health Protection Act was effective for plan years beginning on or after January 1, 1998, and the Final Rule effective January 1, 2009. This plan reflects the final rules effective January 1, 2009.

Healthy Beginnings Prenatal Benefits: Benefits for maternity will automatically be provided based on plan benefits and will be paid as any other benefit, unless the mother has timely enrolled in the Healthy Beginnings Program within the first trimester or 14 weeks of pregnancy or within 60-days of becoming covered under this plan. There shall be no penalty applied for failure to pre-certify the hospital stay as provided above.

For mothers enrolled in the Healthy Beginnings Program, enrollment material and information are provided by the KTF Pre-certification Office. Forms may be requested from your Trust Office or the Compliance Office.

Pre-certification Not Required: There shall be no requirement to pre-certify the hospital stay for maternity for up to 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. This stay begins with the later of:

1. If delivery is in the hospital, it begins at the time of the delivery or delivery of your last child if more the one newborn; or
2. If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted to the hospital as an inpatient in connection with childbirth.

Pre-certification is required for any extended hospital stay for the mother or the baby beyond 48 hours for vaginal delivery or 96 hours for cesarean delivery.

Newborn Documentation Required in Writing: Newborns are automatically deemed enrolled if family coverage was in effect prior to birth; however, documentation must still be provided in writing of the newborn and coverage information of both parents must be on file and updated if there has been any change, so a determination of which plan is primary and which plan is secondary for the baby's claims.

Newborn Enrollment Required: If only single coverage was in effect at the time of birth, the newborn must be enrolled within 30-days of birth. Before claims can be paid for any newborn, the plan must be notified in writing of the newborn's name and date of birth. Documentation of the newborn (birth certificate and social security number) must be provided within 60-days of birth. Additional time will be permitted if reasonable efforts have been made to get the birth certificate and Social Security number of the newborn. Documentation of both parents' coverage for the newborn and date of birth of both parents must be provided in writing, even if the parents are not married.

Initial enrollment is defined as being the date a member notifies the plan of the newborn's birth (or adoption) and requests enrollment forms and information. Written enrollment of the newborn or adoption must be timely provided to cover the newborn from birth. Timely enrollment shall be within 30-days of birth or no later than 14-days following the date the member notifies the plan of the birth and requests enrollment material. Failure to complete an enrollment form will result in the baby not being covered.

If family coverage is in effect, a newborn is automatically deemed to be covered. However, members with family coverage must still enroll the baby and provide a birth certificate and social security number before claims can be paid.

PATIENT RIGHTS NOTICE

This plan is exempt from Title I of ERISA because it is considered a Governmental Plan. However, in general this plan has chosen to abide by most ERISA rules or has adopted comparable rules. As participants in the Plan, employees are entitled to certain rights and protection:

1. Examine, without charge, all documents including contracts and collective bargaining agreements at the Plan Administrator's office and at other specified locations, such as work sites and union halls; and
2. Obtain copies of all Plan documents and other Plan information upon written request to the plan administrator. The administrator can request a reasonable charge for duplicated copies. Eligible employees will be given a copy of the Summary Plan Description or plan without charge.

In addition, the Trustees and other Plan fiduciaries have a duty to manage plan assets prudently and in the best interest of plan participants and beneficiaries. No one, including the employer, unions, or any other entity, may fire an employee or otherwise discriminate against an employee, in any way, to prevent him/her from obtaining a welfare benefit, or from exercising employee rights. If an employee's claim for a welfare benefit is denied in whole or in part, the employee must receive a written explanation for the reason for denial. Employees have the right to have the Plan reviewed and reconsider any claim.

If you should have any questions about the Plan, please contact the Plan administrator. The "Summary Plan Description" provides comprehensive information about the Plan. Alternate beneficiaries and children covered under a qualified medical child support order (QMCSO), considered participants, are protected under the above rules the same as any employee for all purposes under the Plan. The employer/plan sponsor has the full, absolute, and discretionary right to amend, modify, suspend, withdraw, discontinue, or terminate the Plan, in whole or in part, at any time, provided timely notice is given, as required by HIPAA, in the Important Plan Information at the beginning of the plan.

See also HIPAA Privacy and Patient’s Rights Policy.

PREVENTIVE SCREENINGS NOTICE

Please refer to the Medical Schedule of Benefits in Part A for preventive benefits paid at 100% by the Plan with no copay, coinsurance or deductible when provided by an eligible PPO Provider, which is limited to the following providers for any member who is not enrolled as an Out of Area (OOA) retiree or student. OOA members may use those providers as permitted by the Plan *(See Part A for OOA benefits and providers).*

1. KTF PPO Provider
2. Medicare Providers for Medicare Primary Members

Changes to preventive care requirements under the Affordable Care Act (ACA) will be effective at the beginning of the Plan Year following notice of changes. **If you receive other non-preventive treatment during an office visit, you will be responsible for the office visit copay.** Non-preventive treatment will be covered as provided by the Plan. Information on preventive care can be found at www.healthcare.gov.

Guidelines for preventive treatment are based on the recommendations or guidelines of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act section 2713 and implementing rules. New requirements will become effective as of the first day of the Plan Year on or following one year after the date the requirements are finalized.

Any change in mandated preventive benefits under the Affordable Care Act due to Supreme Court rulings and/or specific changes enacted by Congress to the Affordable Care Act shall be incorporated by reference and shall become effective the later of (1) the first day of the month beginning at least 60-days after the ruling or enactment or (2) the effective date as mandated by law, rule, regulations or determination by the courts.

Abdominal aortic aneurysm screening-men:	One-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75, who have ever smoked.
Alcohol misuse counseling:	Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
Anemia screening - pregnant women:	Routine screening for iron deficiency anemia in asymptomatic pregnant women.
Bacteriuria screening - pregnant women:	Screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation, or at the first prenatal visit, if later.
BRCA screening - counseling:	Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes referred for genetic counseling and evaluation for BRCA testing.
Blood pressure screening:	Screening for high blood pressure in adults aged 18 and older.
Breast cancer screening:	Screening mammography for women with or without clinical breast examination every 1-2 years for women aged 40 and older *(unless Plan provides for an earlier age).*

Breastfeeding counseling:	Interventions during pregnancy and after birth to promote and support breastfeeding.
Cervical cancer screening:	Screening for cervical cancer in women who have been sexually active and have a cervix.
Chlamydia infection - screening non-pregnant women:	Screening for Chlamydia infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.
Chlamydia Injections:	Are covered for both young men and women to age 24.
Cholesterol abnormalities screening - men 35 and older:	Screening men aged 35 and older for lipid disorders.
Cholesterol abnormalities screening - men 20-35:	Screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol abnormalities screening for Women 45+:	Screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol abnormalities screening for Women 45+:	Screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.
Colorectal cancer screening (Covered by KTF every 5 years at 45):	Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at 50 years and continuing to age 75 years. The risks and benefits of these screening methods vary.
Depression screening:	Adolescents
Diabetes screening:	Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (treated or untreated) greater than 135/80 mm Hg.
Hearing loss screening - newborns:	Screening for hearing loss in all newborn infants.
Healthy diet counseling:	Intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
Hemoglobinopathies screening - newborns:	Screening for sickle cell disease in newborns.
Hepatitis B screening - pregnant women:	Screening for hepatitis B virus infection in pregnant women at their first prenatal visit.

HIV screening:	Clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
Hypothyroidism screening - newborns:	Screening for congenital hypothyroidism in newborns.
Newborn screenings:	SACHDNIC Recommended Screenings for Core and Secondary Conditions are covered. *See the Final Interim Regulations.*
Obesity screening and counseling – adults:	Clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Osteoporosis screening - women:	Women aged 65 and older should be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporosis fractures.
PKU screening - newborns:	Screening for phenylketonuria (PKU) in newborns.
Rh incompatibility screening:	Repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)- negative.
Sexual Transmitted Infection (STI) counseling:	High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Syphilis screening:	Clinicians screen persons at increased risk for syphilis infection.
Tobacco use counseling:	Clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Group counseling is not covered as a preventive benefit.
Visual acuity screening in children:	Screening to detect amblyopic, strabismus, and defects in visual acuity in children younger than age 5 years.

Preventive Medications Notice Including Certain OTC Drugs

Over the counter (OTC) medications may be covered at 100%. For example, if your doctor prescribes one aspirin a day and you are 45 or older. Medications available as a prescription item may be filled at retail or through mail order without copay provided you meet the following age and condition requirements as of the effective date of these regulations, which is the first day of the Plan Year on or following September 23, 2010. A copy of the prescription can be submitted to KTF Compliance Office so they may put in place the necessary plan override with the Prescription Benefit Manager.

All drugs are limited to generic drugs unless the only available drug is a brand drug for a specific condition. If a comparable generic drug is available, any brand drug will be subject to the normal brand copay.

Aspirin to prevent CVD – men (covered by KTF Plan after age 45):	The use of aspirin for men aged 45 to 79 years when the potential benefit due to a reduction in myocardial infractions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
Aspirin to prevent CVD – women (covered under KTF Plan after age 45):	The use of aspirin for women aged 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
Breast cancer preventive medication:	Clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.
Dental caries chemoprevention - preschool children:	Primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6-months of age whose primary water source is deficient in fluoride. Available by prescription.
Folic acid supplementation (prior authorization required):	All women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 mg) of folic acid. **(Note: Prenatal vitamins are covered through ProAct with your Rx card.)**
Gonorrhea prophylactic medication - newborns:	Prophylactic ocular topical medication for all newborns against gonococcal ophthalmic neonatorum. Available by prescription.
Fluoride:	Fluoride to age 19 for cavity prevention.
Iron supplementation in children (to age 1 only):	Routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
Routine Immunizations and Vaccinations for Children:	Immunizations and vaccinations as required under the Health Care Reform Act will be covered at 100%. Please go to www.ktftrustfund.com for a current listing of covered immunizations and vaccines and the recommended schedule. If the only service provided during an office visit is the administration of a preventive immunization or vaccine, no copay will apply for the office visit. If the office visit includes services that are non-preventive in nature, office visit copay will apply.
Adult Vaccinations:	*See Tables of Recommended Immunizations for adults at* www.ktftrustfund.com. These vaccinations are covered at 100%.

Preventive Benefits for Plan Years Beginning After August 1, 2012

Type of Preventive Service	HHS Guideline for Health Insurance Coverage	Frequency
The following mandated benefits under the Affordable Care Act are subject to change at any time. Mandated changes under the regulatory process are not effective until the first day of the Plan Year following adoption and announcement of such requirements. The following benefits are limited to KTF PPO Providers only unless you are an enrolled Out of Area (OOA) member. Any medications are limited		

to generic only. Brand drugs will be subject to normal copays. Preventive screening and counseling are covered at 100% with no cost sharing so long as these services are provided by a KTF PPO provider and no other non-preventive screening, tests, or exam is provided during the same visit.		
Breastfeeding support, supplies, and counseling. **	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.	In conjunction with each birth.
Counseling for sexually transmitted infections. **	Counseling on sexually transmitted infections for all sexually active women.	Annual.
Counseling and screening for human immune-deficiency virus. **	Counseling and screening for human immune-deficiency virus infection for all sexually active women.	Annual.
Contraceptive methods and counseling. ** *(See note on next page.)*	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. Any abortion related drug or procedures are excluded. Mandatory Generic and Mail Order rules will apply to all oral contraceptives and contraceptive drugs are limited to generic drugs. Brand drugs will be subject to normal Rx copay.	As prescribed, except that the morning after pill is not covered. Other abortion treatment is not covered by the plan, except as specifically provided in the Schedule of Benefits.
Human papillomavirus testing. **	High-risk human papillomavirus DNA testing in women with normal cytology results.	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
Screening for gestational diabetes. **	Screening for gestational diabetes.	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Screening and counseling for interpersonal and domestic violence. **	Screening and counseling for interpersonal and domestic violence.	Annual.
Well-woman visits. ** (Includes Pre-natal care)	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including **preconception and prenatal** care. This well-woman visit should, where appropriate, include other	Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.

	preventive services listed in this set of guidelines and PPACA Section 2713.	

Note: The July 2011 Institute of Medicine (IOM) report entitled Clinical Preventive Services for Women: Closing the Gaps concerning individual preventive services that may be obtained during at least one well-woman preventive service visit annually, that may include the following: **

1. Improved screening for cervical cancer, counseling for sexually transmitted infections, and counseling and screening for HIV;
2. A fuller range of contraceptive education, counseling, methods, and services so that women can better avoid unwanted pregnancies and space their pregnancies to promote optimal birth outcomes;
3. Services for pregnant women including screening for gestational diabetes and lactation counseling and equipment to help women who choose to breastfeed do so successfully; and
4. Screening and counseling for all women and adolescent girls for interpersonal and domestic violence in a culturally sensitive and supportive manner.

** If you receive other non-preventive treatment, testing or exam during a preventive office visit, the normal office visit copay will apply. If services are limited to preventive screenings, counseling and exams with a PPO provider, there shall be no cost sharing and the visit will be covered at 100%.

RIGHT TO AMEND OR TERMINATE A PLAN

The Plan has been established as a 501(c) (9) Employee Benefit Trust (VEBA Trust) or a Section 115 Trust, pursuant to a separate negotiated collective bargaining agreement. The Trust is funded by contributions from the School District, which is a governmental entity, pursuant to the bargaining agreement, for the purpose of allowing the teachers union to offer its own group health plan to eligible members. Funding is in direct proportion to the number of members who elect coverage under the Plan.

The Benefit Trust is managed by a separate Board of Trustees. The Trust oversees the operation of the Plan, including the PPO Network, payment of claims, compliance, actuarial overview, plan design and benefit consulting.

The Benefit Trust reserves the right to amend, change, or terminate the Plan at any time, including any changes to modify coverage for retirees, at any time, subject to timely notice of change, as required by HIPAA. The benefits provided by the Plan can be modified, amended, changed, limited, or added, based on maintaining overall viability of the Plan and includes balancing benefits provided in relationship to utilization, cost of benefits versus the funding received for benefits. All benefits under the Plan are subject to the right of the Plan to be amended or modified at any time by the Plan Sponsor or Board of Trustees. Additionally, changes may be made to benefits, or the cost of benefits, as a result of changes in the collective bargaining agreement.

The purpose of the Plan is to provide the best possible level of benefits, based upon the level of funding received. The benefits under the Plan are comparable and, if possible, significantly better than benefits provided under other plans offered by the school district. Our goal is to use the savings realized, as a result of better and more cost-effective management of available dollars, to expand benefits and bring more services to the membership. A comparison of the benefits provided and the relative cost to members for the benefits and the cost of other benefit programs will reflect the success of this objective.

In the event the Plan terminates, the remaining assets of the Trust, if any, would be disbursed to the membership in accordance with the rules of the VEBA or 501(c) (9) Trust.

Advance notice of Plan changes is subject to advance notice requirements under the Health Care Reform Act of 2010.

SPECIAL ENROLLMENT RIGHTS NOTICE

What are a plan's obligations with respect to special enrollment when a new dependent through marriage, birth, adoption, or placement for adoption?

Employees, as well as their spouses and dependents may have special enrollment rights after a marriage, birth, adoption, or placement for adoption. In addition, new spouses, and new dependents of retirees in a group health plan may also have special enrollment rights after a marriage, birth, adoption, or placement for adoption.

If a special enrollment opportunity is available, the individual must request special enrollment within 30-days of the marriage, birth, adoption, or placement for adoption that triggered the special enrollment opportunity. In the case of marriage, enrollment is required to be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan. In the case of birth, adoption or placement for adoption, enrollment is required to be effective no later than the date of such birth, adoption, or placement for adoption.

Are plans and issuers required to disclose individuals' special enrollment rights?

Yes. A description of special enrollment rights must be provided to employees on or before the time they are offered the opportunity to enroll in the group health plan, such as that in the model description.

What are employee's responsibilities?

Employees must immediately notify the Plan of any special enrollment situation to take advantage of their special enrollment rights. The standard time frame is to provide notice within 30-days of the event unless a longer period is provided. Under the Plan, the HIPAA 30-day period is extended to 60-days.

What new information do group health plans have to give to participants and beneficiaries?

HIPAA and other recent laws made important changes in ERISA's disclosure requirement for group plans. Under current Department of Labor interim disclosure rules, group health plans must improve their summary plan descriptions (SPDs) and summaries of material modifications (SMMs) (documents employers are required to provide to employees at certain key intervals) in four major ways to:

1. Notify participants and beneficiaries of material reductions in covered services or benefits (for example, reductions in benefits or increases in deductibles and co-payments) generally within 60-days of adoption of the change. This compares to current requirements under which plan changes can be disclosed as late as 210 days after the end of the plan year in which a change was adopted.
2. Disclose to participants and beneficiaries' information about the role of issuers (e.g., insurance companies and HMOs) with respect to their group health plan. In particular, the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer and the nature of any administrative services (e.g., payment of claims) provided by the issuer.
3. Tell participants and beneficiaries which Department of Labor office they can contact for assistance or information on their rights under ERISA and HIPAA.
4. Tell participants and beneficiaries that federal law generally prohibits the plan and health insurance issuers from limiting hospital stays for childbirth to less than 48-hours for normal deliveries and 96-hours for cesarean sections.

What is the definition of a material reduction in covered services or benefits that is subject to the new 60-day notice requirement?

Under the interim disclosure rules, a material reduction in covered services or benefits means any modification to a group health plan or change in the information required to be included in the summary plan description that, independently or in conjunction with other contemporaneous modifications or

changes, would be considered by the average plan participant to be an important reduction in covered services or benefits under the group health plan.

The interim rules cite examples of reductions in covered services or benefits as generally including any plan modification or change that:

1. Eliminates benefits payable under the plan.
2. Reduces benefits payable under the plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations.
3. Increases deductibles, co-payments, or other amounts to be paid by a participant or beneficiary.
4. Reduces the service area covered by a health maintenance organization.

Establishes new conditions or requirements (e.g., preauthorization requirements) to obtain services or benefits under the plan.

Can employers use e-mail systems to communicate these new disclosures to employees, and if so, do employees have a right to get a paper copy of the information from their plan?

Yes. The interim disclosure rules provide a safe harbor for using electronic media (e.g., e-mail) to furnish group health plan SPDs, summaries of material reductions in covered services or benefits and other SMMs (summaries of plan modifications and SPD changes). To use the safe harbor, among other requirements, employees must be able to effectively access at their worksite documents furnished in electronic form. Participants also continue to have a right to receive the disclosures in paper form on request and free of charge.

Although the interim rule is not the exclusive means by which electronic media can be used to lawfully communicate plan information, the HIPAA safe harbor is limited to group health plans. The Department of Labor is considering extending the rule to other plans, including pension plans, and to other plan disclosures, but is exploring whether special precautions are necessary to ensure the confidentiality of electronically transmitted individual account or benefit-related information.

Who enforces HIPAA?

The Secretary of Labor enforces the health care portability requirements on group health plans under ERISA, including self-insured arrangements. In addition, participants and beneficiaries can file suit to enforce their rights under ERISA, as amended by HIPAA.

Note: The KTF Plan is self-funded. Plans of a non-federal governmental unit, such as plans of a state, county, or city unit, including a school district, even when the plan is operated by the union for the employees of such governmental entity are subject to the Public Health Service Act and federal oversight—not state laws that apply to fully insured plans.

The Secretary of the Treasury enforces the health care portability requirements on group health plans, including self-insured arrangements. A taxpayer that fails to comply may be subject to an excise tax.

States also have enforcement responsibility for group and individual requirements imposed on health insurance issuers, including sanctions available under state law. If a state does not act in the areas of its responsibility, the Secretary of Health and Human Services may make a determination that the state has failed to substantially enforce the law, assert federal authority to enforce, and impose sanctions on insurers as specified in the statute, including civil money penalties.

Are there special rules or exemptions for Self-Funded Non-Governmental Plans?

Prior to the passage of the Affordable Care Act (ACA), these plans were able to "opt out" of many of the Public Health Service (PHS) Act provisions, such as those dealing with Summary Plan Descriptions, disclosure rules, etc. ACA made a number of changes mandating Non-Governmental Plans could no longer

opt out of many of the requirements of Title XXVII. Self-funded plans remain exempt from state insurance laws, which remain applicable to fully insured plans.

What must I do to make a special enrollment change?

First, you must confirm what changes were permitted to make based on the actual event. You must complete an enrollment form and update the form to reflect the changes you wish to make. All enrollments are subject to review and approval by the KTF Compliance Office. You will be notified if any change is determined not to be eligible for special enrollment rights.

Your changes must be consistent with the event. For example, if you opted out of KTF coverage due to coverage under your spouse's plan, if your spouse changes his/her plan during their plan's open enrollment period or if your spouse loses their coverage, either of these events would permit you to enroll in KTF coverage for you and eligible family members. You need to provide a HIPAA Certificate of event or some form of documentation showing the actual event.

If you have a newborn and your spouse terminates his coverage, you may then enroll both the newborn and your spouse due to the birth. If you also have stepchildren that were not covered under your spouse's plan or your plan previously, they would not be eligible to be added due to the birth of your child. The stepchildren could only be added during the next Open Enrollment period, UNLESS you indicated on your initial enrollment that your stepchildren were not being covered due to their being covered under another plan (ex-spouse's plan) and the children were losing their coverage under the ex-spouse's plan.

Special Enrollment – Qualified Life Event (QLE) Chart**					
Qualifying Life Event (QLE) – Must request change within 60-days after the event and all changes must be prospective (usually the first day of the month following the date you notify the Plan of a change in status). ** Note: Most Plans require changes to be made within 30-days of event.	From Not Enrolled to Enrolled	ENROLLMENT TYPE			
		Increase Coverage	Decrease	Cancel Coverage	Change from one Plan to Another Plan
Adding a previously non-enrolled family member**	No	No	No	No	No
Acquiring/adding a new eligible family member (birth, adoption, marriage, dependent status change)	No	Yes	No	No	No
Losing a covered family member (death, divorce, or legal separation)	No	No	Yes	No	No
Losing other medical/dental/vision coverage (spouse or dependent loses their coverage)	Yes	Yes	No	No	No
Spouse/dependent acquires other coverage due to different open enrollment or new employment	Yes	No	Yes	Yes	No
Going on active military duty, non-pay status	No	No	No	Yes	No
Return to pay status from active to military duty	Yes	No	No	No	No
Retirement of Primary Member	No	No	No	No	No
Moving Outside Primary Coverage Area – Eligibility for Out of Area (OOA) Status	No	No	No	No	Yes
Loss of dependent eligibility	No	No	Yes	No	No

** All changes must be *consistent* with the actual event. Changes may be denied if they are inconsistent with the facts of a given special enrollment situation.

SUBROGATION NOTICE AND PLAN'S RIGHT OF RECOVERY

If you are injured, as a result of another party, and this plan advances funds to pay your claims, the Plan has the right to recover its actual expenses out of any recovery you may receive in conjunction with any recovery or payment by the other party and/or their insurance. The most common example is where a person is injured at work. Work related injuries are not covered at all, nor will the Plan advance funds for such injuries. You must deal directly with the Workers Compensation providers.

Examples of typical situations where subrogation rules apply are as follows:

1. You are in a motorcycle or automobile accident. The car insurance, both the vehicle you are driving as well as the vehicle of any other driver that may be involved in the accident if they are at fault, provides the Primary coverage in these situations.
2. You slip and fall in a store or on private property due to some defect or situation that caused you to fall, for example you slip and fall when you step on an area of the floor that was not properly cleaned after a bottle of olive oil broke on the floor. You break your hip in the fall or suffer some other injury.
3. You have heart surgery, and a pacemaker is placed in your chest to monitor your heart. Several years later, there is a class action suit against the manufacturer due to a flaw in the monitor that could be fatal. Individuals who received a monitor from the company who manufacture that particular monitor are liable for the damages. The recommendation is that individuals see their doctor and make arrangement to have the monitor replaced.

It may take years before any settlement is reached in conjunction with the above situations. When the Plan advances payment on these claims, this relieves the member of having to pay for these expenses out of pocket and then waiting for reimbursement when the settlement is reached. When providers are harassing members for collections it generally applies a lot of undue stress to force them into settling early or for lower amounts. Accordingly, it is only "fair" that the Plan be reimbursed for the expenses it advances.

The plan policy has been changed to recognize the principle of "unjust enrichment." Therefore, any subrogation claim will be adjusted by a pro-rata share of the attorney and other recovery expenses based on the gross settlement and the total fees as a percentage of the gross settlement.

Example: Subrogation Claim: $30,000 (medical bills advanced/paid by the Plan)

Member is Awarded: $150,000 (Gross Settlement)

Legal Fees are 35%: $52,500; or

Net Settlement: $97,500

Subrogation Claim as a % of Total Claim: $30,000/$150,000 = **20%**

Net Subrogation Claim's pro-rata Share of the Expenses: 20% x $52,500 = **$10,500**; or

Subrogation Claim Reduced by the legal fees as a %: 35% x $30,000 = **$10,500**

Net Subrogation Claim: **$19,500** ($30,000 - $10,500), to be paid out of the Net Settlement

Net Settlement to Member: $97,500 - $19,500 = **$78,000**

USERRA (UNIFORMED SERVICE) NOTICE

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS NOTICE (USERRA) AS MODIFIED BY THE VETERANS BENEFITS IMPROVEMENT ACT OF 2004.

USERRA provisions cover a wide range of benefits and employment issues for employees (including volunteers and reservists) who join any of the United States Uniformed Services. This summary is not intended to be a complete or comprehensive summary of all your USERRA rights. For additional information, go to http://www.dol.gov/vets/#userra.

Contact your Human Resource department for additional questions, or you can contact the KTF Compliance Office for assistance. The provisions of USERRA, as modified by final regulations and the Veterans Benefits Improvement Act of 2004, are incorporated herein by reference. The following is a brief summary of the basic protection under USERRA, which provides protection for individuals serving in the uniformed services (military).

Health Benefits Section 4317

The law provides for health benefit continuation for persons who are absent from work to serve in the military, when COBRA does not cover their employers. Employers with less than 20 employees are exempt from COBRA. If a person's health coverage terminates because of an absence due to military service, the person can elect to continue health plan coverage, for up to 24 months after the absence begins, or for the period of service (plus the time allowed to apply for reemployment), whichever period is the shortest. The person cannot be required to pay more than 102% of the full premium for coverage. If the military service is less than 30-days, the person cannot be required to pay more than the normal employee share for any premium.

Exclusions or Waiting Periods

Section 4317(b): Waiting periods have been provided to persons if they have not been absent for military service. However, exceptions apply to disabilities determined by the Secretary of Veterans' Affairs to be service connected.

Employee Rights under USERRA

The pre-service employer must reemploy service members returning from a period of service in the uniformed services, if those service members meet the five (5) criteria:

1. The person must have held a civilian job;
2. The person must give notice to his/her employer that he/she is leaving the job for service in the uniformed services, unless giving notice is precluded by military necessity, otherwise impossible, or unreasonable;
3. The cumulative period of service must not exceed five (5) years;
4. The person cannot be released from service due to dishonorable or other punitive conditions; and
5. The person must report back to the civilian job in a timely manner or submit a timely application for reemployment.

USERRA establishes a five (5) year cumulative total on military service with a single employer, with exceptions allowed for certain situations, such as: call-ups during emergencies, reserve drills and annually scheduled active duty for training.

USERRA allows an employee to complete an initial period of active duty that exceeds five (5) years (i.e., an enlistee in the Navy nuclear power program is required to serve six (6) years).

Under USERRA, restoration rights are based on the duration of military service rather than the type of military duty performed (i.e., active-duty training or inactive duty), except for fitness-for-service examinations. The time limits for returning to work are as follows:

1. **<u>Less than 31-days service</u>**: By the beginning of the first regularly scheduled work period, after the end of the calendar day of duty, and time required to return home safely, and an eight (8) hour rest period. If this is impossible or unreasonable, then as soon as possible.
2. **<u>31 to 180 days</u>**: The employee must apply for reemployment no later than 14-days after completion of military service. If this is impossible, or unreasonable through no fault of the employee, then as soon as possible.
3. **<u>181 days or more</u>**: The employee must apply for reemployment no later than 90-days after completion of military service.
4. **<u>Service-connected injury or illness</u>**: Reporting or application deadlines are extended for up to two (2) years for persons who are hospitalized or convalescing.

Protection from Discharge

Persons returning from active duty for training were not explicitly protected under the old law. Under USERRA, a reemployed employee cannot be discharged without cause, as follows:

1. For one year after the date of reemployment, if the person's period of military service was for more than six (6) months (181-days or more), [Section 4316(c) (1)].
2. For six (6) months after reemployment if the period of military service was for 31 to 180 days.
3. A person who serves for 30 days or less is not protected from discharge without cause. However, they are protected from discrimination because of military service or obligation, [Section 4316(c) (2)].

Seniority Rights Section 4316(a)

Reemployed service members are entitled to seniority and all rights and benefits based on the seniority they would have attained with reasonable certainty had he/she been continuously employed. A right or benefit is seniority-based if it is determined by or is accrued based on length of service. On the other hand, a right or benefit is not seniority-based if it is based on compensation for work performed or is subject to a significant contingency.

<u>Rights Not Based on Seniority, Section 4316(b)</u>: Departing service members must be treated as if they are on a leave of absence. Consequently, while they are away, they must be entitled to participate in any rights and benefits, not based on seniority, that are available to employees on nonmilitary leave of absence, whether paid or unpaid. If there is a variation of different types of nonmilitary leave of absence, the service member is entitled to the most favorable treatment as long as the nonmilitary leave of absence is comparable. <u>Example</u>, a three (3) day bereavement leave is not comparable to active duty for two (2) years. A returning employee is entitled to non-seniority rights and benefits available at the time he/she left for military service, and also for benefits that became effective during his/her service.

<u>Forfeiture of Rights, Section 4316(b)(2)(A)(ii)</u>: If, prior to leaving for military service, an employee knowingly provides clear written notice of intent not to return to work after military service, the employee waives entitlement to leave-of absence rights and benefits not based on seniority. When providing the notice, the employee should be aware of his/her lost rights and benefits. If the employee lacks this awareness, or is otherwise coerced, the waiver will be ineffective. A notice of intent not to return waives

only leave-of-absence rights and benefits; they cannot surrender other rights and benefits that a person would be entitled to under the law, particularly reemployment rights.

USERRA Rules for Pension and Retirement Plans

Pension Plans under Section 4318 and tied to seniority are given separate and detailed treatment under the law. The law provides:

1. A reemployed person must be treated as not having incurred a break in service with the employer maintaining a pension Plan, [[Section 4318(a)(2)(A)];
2. Military service must be considered service with an employer for vesting and benefit accrual purposes, [Section 4318(a)(2)(B)];
3. The employer is liable for funding any resulting obligation under Section 4318(b) (1) and 4318(b) (2). The reemployed person is entitled to any accrued benefits from employee contributions, only to the extent the employee repays the employees' contributions;
4. Covered Plan, Section 4318: A "pension plan" that must comply with the requirements of the reemployment law would be any plan that provides retirement income to employees until the termination of employment or later. Defined benefits plans, defined contribution plans, and profit-sharing plans that are retirement plans are covered; and
5. In a multi-employer defined contribution pension plan the sponsor maintaining the plan can allocate the liability of the plan for pension benefits accrued by persons who are absent for military service. If no allocation or cost-sharing arrangement is provided, the full liability to make the retroactive contributions to the plan will be allocated to the last employer employing the person before the period of military service or, if that employer is no longer functional, to the overall plan. Within 30-days after reemployment, an employer, who participates in a multi-employer plan, must provide written notice to the plan administrator of the person's reemployment *[See Section 4318(b) (1)].*

Employee Contribution Repayment Period

Repayment of employee contributions can be made over three (3) times the period of military service but no longer than five (5) years, [Section 4316(c) (2)].

For purposes of determining an employer's liability or an employee's contributions under a pension benefit plan, the employee's compensation during the period of his/her military service will be based on the rate of pay the employee would have received from the employer, except for his/her absence during the period of service. Section 4318(b) (3) (B) provides that if the employee's compensation was not based on a fixed rate, the determination of the rate is not reasonably certain, on the basis of the employee's average rate of compensation during the 12-month period immediately preceding the period (or, if shorter, the period of employment immediately preceding the period), [Section 4318(b) (3) (A)].

Funding of Benefits, Section 4316(b)(4): Service members can be required to pay the employee cost, if any, of any funded benefit to the extent other employees on leave of absence are required to pay.

Vacation Pay – Section 4316(d)

Service members must, at their request, be permitted to use any vacation that had accrued before the beginning of their military service instead of unpaid leave. Service members cannot be forced to use vacation time for military service continues to be the law.

Portability Rights

The Plan does not have any pre-existing exclusions; therefore, it is important that members understand their portability rights upon leaving the Plan. HIPAA's portability rules require that plans must give an employee and his/her dependent credit for prior coverage for the purpose of any pre-existing exclusion period the plan may have for pre-existing conditions. A HIPAA Certificate provides members with verification of his/her beginning and ending period for any prior coverage. If there has not been a 63-day break in coverage, any prior coverage must reduce or offset any pre-existing waiting period or exclusion period, as defined below. A HIPAA certificate must be provided, without charge, at the request of any covered member, within 24 months (2 years) of the date his/her coverage ended. A Certificate of Coverage should be provided automatically when a qualifying event occurs for COBRA purposes. The certificate should reflect Final HIPAA regulations and a notice of your rights.

Right to get in another Plan under HIPAA's Special Enrollment Rules

Under HIPAA, if you lose your group health or dental coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Additional special enrollment rights: marriage, divorce, separation, birth, adoption, and placement for adoption. You should request special enrollment as soon as possible following the date you lose coverage.

Prohibition Against Discrimination Based on a Health Factor

Under HIPAA, a group health plan cannot keep you or your dependents out of the plan based on anything related to your health. A group health plan cannot charge you or your dependents more for coverage, based on health, than the amount charged a similarly situated individual.

Right to Individual Health Coverage

Under HIPAA, if you are an "HIPAA Eligible Individual" you have the right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without pre-existing condition exclusions. If you are interested in obtaining individual coverage and meet the other criteria, you should apply for the coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break in coverage. To be an eligible individual, you must meet the following requirements:

1. Have had coverage for at least 18 months without a break in coverage of 63 days or more;
2. Recent coverage under a group health plan, as evidenced by a HIPAA Certificate of Coverage;
3. Your group coverage was not terminated because of fraud or nonpayment of premiums;
4. You are not eligible for COBRA continuation coverage, or you have exhausted your COBRA benefits, or continuation coverage under similar state provisions;
5. You are not eligible for another group health plan, Medicare, or Medicaid and do not have any other health coverage; and
6. The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

State Flexibility

States may require insurers and HMOs to provide additional protections to individuals in that state (state of residence). This notice covers only minimum Federal requirements.

Pre-Existing Condition (Under HIPAA – Post Healthcare Reform)

Pre-existing conditions are no longer permitted under Healthcare Reform enacted in 2010.

Special Rules for Employees Covered by the Trade Act of 2002 (TAA)

Workers, whose employment is adversely affected by international trade, may be entitled to receive Trade Adjustment Assistance (TAA) and a 65% health coverage credit (HCTC). You could be entitled to a Second COBRA Election Period, if you find the Trade Act covers you. For more information on TAA, contact the Department of Labor, Employment and Training Administration, at (877) US2-JOBS, or on-line at **www.doleta.gov/tradeact**. For additional information on HCTC, call the IRS at (866) 638-4282.

How to Get a HIPAA Certificate and How Often May I Request a Certificate?

To get a HIPAA Certificate, contact the KTF Compliance Office, or call toll-free (844) 583-3863. A HIPAA Certificate will automatically be mailed to covered members when a COBRA event occurs. You should keep this Certificate in a safe place and be sure to give a copy of the certificate to your new plan when you enroll for new coverage. If you do not receive a HIPAA Certificate within two (2) weeks following your termination of employment, please contact the Compliance Office.

You are entitled to request a HIPAA Certificate any time while actively covered and for up to 24 months following the termination of your coverage.

For More Information

If you have questions about your HIPAA rights, you can contact your state insurance department, or the U. S. Department of Labor, Employee Benefits Security Administration (EBSA), toll-free at 1-866-444-3272 (for free HIPAA publications, ask for publications concerning changes in healthcare laws). You can also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are available on the Internet. Go to the DOL's interactive web pages (Health Laws) at: **http://www.dol.gov/ebsa** or **www.cms.hhs.gov/hipaa**.

WASTE, FRAUD AND ABUSE POLICY

Violation of the of waste, fraud and abuse rules as defined by law and as defined in Part B of the Plan may result in any or all the following actions. This policy is applicable to any covered member or dependent as well as any provider who provides medical, dental, or behavioral services, equipment, supplies or any other service to a covered individual:

1. Denial of or reduction of a benefit payment, including charges by a PPO provider if the Plan determines that the provider's charges are excessive or inappropriate for the services rendered.
2. Filing of a formal complaint with the appropriate licensing authority.
3. Member or Provider will be responsible for all expenses due to any action that is deemed to violate this policy. For example, a member will be responsible for all excess charges resulting from:
    a. Failure to notify the Plan and/or Providers of other health or dental insurance coverage in effect for any member, including Medicare coverage, resulting in overpayment of claims.
    b. Failure to enroll in Medicare Part A and B on behalf of any covered member when they are first eligible and no longer covered under an employee who is actively at work with medical coverage. Members who are eligible for Medicare on account of Social Security disability are required to enroll for both Medicare A and B after 24 months of disability or when they are eligible by reason of End Stage Renal failure or Lou Gehrig's disease.
    c. Failure to advise plan of third-party liability or any action against a third party due to injury or illness caused by such party for which the plan has advanced payment for claims related to the third-party liability or action against a third party. For example, you have surgery to replace a defective pacemaker and are a party in interest in Class Action against the manufacturer

See Part B for a complete summary of the Plan's Waste, Fraud and Abuse (WFA) rules.

Important Notice to Members: Members are advised the Plan has no contractual control over out of network (NPPO) providers. Therefore, caution is urged in selecting any out of network provider as you may have significantly increased costs. Members are solely responsible for appealing with the provider to waive or reduce any fees that exceed the Plan's allowance. Members are advised to get an advance "quote" from the provider of the procedures or treatment, including CPT Codes, along with their cost. Members or Providers may contact the KTF Compliance Office for what will be covered and the members out of pocket cost for such treatment or procedure.