2024 SUMMARY PLAN DESCRIPTION – PART B

(See also Part A for Schedule of Benefits, Part C for Important Notices of Your Rights, and Part D for the Dental Plan)

Important Notices/Disclosures to Members:

Part B and Part C of the KTF plan provide additional general information and details with respect to your benefits. **Part C** includes various notices outlining your benefit rights. Please review this information carefully so that you are familiar with all Plan requirements.

Specific or unique Plan rules are contained in **Part A (Medical Schedule of Benefits)** along with **Part D (Dental Schedule of Benefits)**. **In case 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 shall supersede any general provisions in Part B.**

Please use the Table of Contents to help you locate specific information quickly. Should you need assistance, clarifications of Plan benefits or rules, or if you wish to file a formal written appeal, contact the KTF Compliance Office at (844) 583-3863. It is important that any appeal regarding a denied claim be filed within 180 days following the denial. In the case of a claim that has never been received by the Claims Office in accordance with the claim's instructions on your ID card, claims are deemed to have been automatically denied 180-days following any date of service for non-filing.

See the Penalty Chart in Part A for penalties for late filed claims and/or failure to obtain the necessary pre-certification prior to a procedure as required by the Plan.

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

Restatement Date: July 1, 2020

Last Amendment: June 1, 2012, and July 1, 2012, PPO Amendment

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INTRODUCTION AND IMPORTANT INFORMATION

Specific and unique plan rules are contained in Part A. 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 within the Plan. 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. In the event of a conflict between the Plan provision and any rule of law, including Final Rules or Final Regulations, the rule of law shall apply.

The Information contained in Part B of the Summary Plan Description (SPD) provides additional general information and details with respect to your benefits and your benefit rights.

This plan has been updated to comply with current laws, rules, and regulations, including the Patients Protection and Affordable Care Act of 2010, referred to as PPACA or ACA (Affordable Care Act). Due to the many required disclosure notices, a new PART C has been added to the Plan. All employee Notices have been moved to Part C so all notices explaining members' rights are in one place.

The Plan is organized as follows with all notices contained in 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.

ALLOWABLE CHARGES

The Plan **"Allowed,"** or **"Eligible Charges"** are those on which benefits are based, subject to any deductible, copay, or coinsurance per the Schedule of Benefits based on the network status of the provider. On the Explanation of Benefits (EOB), the Eligible or Allowed Charges follow the Actual Charges as submitted by the provider. The following terms are interchangeable and mean the same thing:

- Usual, Customary and Reasonable (UCR)
- Allowable Charges
- Plan Allowance
- Allowed Amount
- Eligible Charges

Important Notice: Excess Charges are those charges in excess of **Eligible Charges**. Members may be liable for such charges when they go out-of-network. Described below is the process used by this Plan to determine the maximum charges it will consider for purposes of determining the Plan's benefit limit and your deductible, copay, or coinsurance.

Regardless of the network status of any provider, the Plan reserves the right to review or audit any claim and to request additional records and documentation where:

1. The actual cost of any item, supply or medical equipment that is outside the PPO Contract or where there are no allowable fees and to limit Eligible Charges to an amount that reflects a reasonable profit.
2. Billed charges appear to be excessive or where the procedure or DRG codes appear to be inappropriate based on the diagnosis codes.
3. Charges appear to be based on excessive billing for supplies and services, upcoding and/or unbundling of charges, which are a violation of the Plan's Waste, Fraud and Abuse provisions.

The Plan has adopted a Waste, Fraud and Abuse Policy. Excessive billing practices, including unbundling and upcoding to increase charges for services are an abuse billing practice and will not be tolerated by the Plan. Please refer to our Waste, Fraud and Abuse Policy in Part C. **The Plan will determine allowable charges by using whatever methodology is most appropriate as set out below for NPPO or out-of-network providers.**

PPO (PREFERRED PROVIDER ORGANIZATION)/NETWORK PROVIDERS

Our PPO allowances are negotiated with each provider who participates in the network. PPO allowances may be based on a standard reduction or on a negotiated fee schedule. For these allowances, the PPO provider has agreed to accept the negotiated reduction and you are not responsible for this discounted amount. In these instances, the benefit paid plus your coinsurance equals payment in full. Excess charges over the Eligible Charges are considered PPO discounts and are written off and the provider may not balance bill to the member.

Eligible charges are always limited to the LESSER OF the negotiated PPO fee or the actual charges submitted by the provider, including any claim using the MS-DRG Codes. In these instances, the benefit paid by the Plan plus your coinsurance equals payment in full.

The Plan's standards for determining **Eligible Charges** have been changed to reflect current methodology which establishes allowable charges based on service provided within a given geographical area. Allowable charges for network providers are based on a negotiated fee schedule or rate with the Plan. Provider contracts may vary from provider to provider. The Plan retains the right to base reimbursement on the respective PPO Contracts, subject to the Plan's waste, fraud and abuse policies as provided below. **When reimbursement is to be based on a percentile of the Medicare rates and there is no established**

Medicare allowable fee or non-Medicare service, the allowable charge shall be based on the allowable charge under Context[4] Healthcare at the 70th percentile.

PPO Network Priority: PPO providers will be paid based on the following priority: MagnaCare Network, KTF Network, then First Health Network, when a provider is in multiple networks.

NPPO (NON-PREFERRED PROVIDERS)/OUT-OF-NETWORK PROVIDERS

To determine our non-PPO Plan allowance, we must first be provided an itemized bill that includes your diagnosis, the services or supplies you received, and the provider's charge for each, using the same types of standard codes, descriptions and other information required for processing by public health care plans like Medicare. If we are not provided the itemization of the services or supplies you received, we will assume they were equivalent to the level and extent of services and supplies typically provided by the providers or facilities most commonly used to treat other plan members with the same principal diagnosis as yours. We will base these equivalent services on claims submitted to the Plan by providers in the same geographic region or a combination of similar geographic regions across the United States.

Based on the itemization of services or supplies received, we will determine the Eligible Charges, which shall be the maximum non-PPO Plan allowance for benefit purposes by applying the following rules in order:

1. Usual, Customary and Reasonable Charges as determined by Context[4] Healthcare, which is an independent firm that maintains a national data base of charges for numerous procedures to determine what the usual, customary, and reasonable charge is based on the 80th percentile.

   Since 1988 Context[4] Healthcare, has established a team of American Health Information Management Association (AHIMA), American Academy of Professional Coders (AAPC), Registered Health Information Technicians and Administrators along with credentialed Health Informatics professionals to provide Medical Practices with a reliable claim editing solution. Context[4] Healthcare's Usual, Customary & Reasonable Fee (UCR) data products provides healthcare payers a statistically valid benchmarking tool to help determine reimbursement and billing rates for medical procedures using CPT® codes. Fees are available for all geographic regions of the United States and presented in multiple percentiles.

   The methodology behind each UCR fee solution is arrayed in percentiles and divided by nearly 260 geo-zip regions with bi-annual updates to refresh existing data. The fee tables are developed using over one billion actual provider charges that are collected annually. Context[4] Healthcare methodology ensures that the UCR fees represent current provider charges with a high degree of statistical accuracy. This comprehensive database provides fees for virtually all CPT® surgery, evaluation and management, radiology, medicine, pathology, and laboratory services. Fee percentiles are provided for more than 250 distinct geographic areas and encompass all 50 states and U.S. jurisdictions. This Plan utilizes the 80th fee percentile.

   The Context[4] Healthcare Medical UCR database was built by extensively analyzing millions of submitted charges. Context[4] Healthcare's staff continuously analyzes and incorporates new fees so that you receive the most current and reliable data available. This database is utilized by many insurers and private plans. In addition to standard fees, the Context[4] Healthcare Medical UCR database provides separate percentiles for the technical and professional components of numerous radiology, pathology, laboratory, and medicine services. This additional flexibility allows equitable payment decisions on bills reporting component charges. Context[4] Healthcare's HCPCS Usual, Customary and Reasonable database is utilized to ensure fair and equitable reimbursement for these supplies and materials which are not described in the CPT® coding system.

   The HCPCS Level 2 system contains more than 2,400 codes. Codes are provided for reporting a wide range of medical and surgical supplies, durable medical equipment, injection supplies, orthotics and prosthetics, enteral and parenteral nutrition, ambulance services, vision services,

hearing services and speech pathology services**. HCPCS codes are alphanumeric and range from A0021 through V5364.** Context[4] Healthcare has established fee values for 95% of those HCPCS codes that can logically be assigned percentiles. Fee percentiles included are the 50th, 55th, 60th, 70th, 75th, 80th, 85th, 90th, and 95th. Unique conversion factors are defined for more than 250 distinct payment areas.

Important Notice to Members and Providers: When deemed necessary for further review of a claim by the Plan, we will also utilize independent consultants and the following (items 2 through 10) to evaluate a claim prior to payment.

2. **Industry Benchmarks**: We consult standard industry guides, such as national databases of prevailing health care charges from identified data sources that are available for our use in a given state or geographic area. Some of the benchmarks that may be used include, but are not limited to, the following:
    a. Previously Accepted Rates by the Specific Provider
    b. Locality-Specific Medicare Rates
    c. National Correct Coding Initiatives Edits (NCCI)
    d. State Workers Compensation Rates
    e. Cost-to-Charge Ratios
    f. Specific Hospital Payments, Charges and Costs Reported by Code
    g. Tricare Reimbursement Rates
    h. OWCP and Tricare State Cost-to-Charge Ratios
    i. Appropriate Adjustments of Modifiers
    j. Financial Data Reported by Hospitals
3. **Data Source Unavailable**: For services or supplies obtained in a state or geographic area where the above data source is unavailable for our use, and for dialysis centers and outpatient dialysis performed at a hospital, our non-PPO Plan allowance is two times the Medicare participating provider allowance for the service or supply in the geographic area in which it was performed or obtained. This Medicare-based allowance is not used for those services where Medicare sets a fixed national payment amount that does not vary geographically (such as blood draws). Medicare fee schedule information for physician services may be obtained at **www.cms.hhs.gov/PFSlookup/**.
4. **Use of Medical Consultants**: Some plan allowances may be submitted to medical consultants who recommend allowances based on standard industry relative value guidelines. For services or supplies for which Medicare does not provide an allowance amount, we may use the current fee schedule used by the federal Office of Workers Compensation (OWCP). OWCP fee schedule information may be obtained at **https://www.dol.gov/OWCP/regs/feeschedule/fee.htm.** For services or supplies that do not have a value currently established by public health care plans such as Medicare or Medicaid, or for implantable devices and surgical hardware, we may use medical consultants to determine an appropriate allowance. We may also conduct independent studies to determine the usual cost of a service or supply in a geographic area, or to establish allowances for services or supplies provided outside the United States. Non-PPO Plan allowance amounts determined per these guidelines include, but are not limited to, ambulatory surgery centers, dialysis centers, surgery, doctor's services, physical therapy, occupational therapy, speech therapy, lab testing and X-ray expenses, implantable devices, and surgical hardware.
5. **Vaccines – Major-Medical Prescriptions with No Established Fee**: Plan allowance for prescription drugs is determined using Average Wholesale Price or other industry-standard reference price data. Reimbursement rates will be limited to 130% of the Average Sales Price (ASP) as established for Medicare reimbursement or the amount determined under review. If the ASP

rates are not available, reimbursement will be limited to Red Book AWP at 120%. This shall not apply to the Plan's specialty pharmacy drugs or major-medical injections that exceed $1,000.

6. **Durable Medical Equipment**: The maximum allowed purchase price will generally be equal to 12 month's rental fee unless another fee is negotiated and approved in advance of purchase. All DME expected to cost over $500 must be pre-approved. Other DME or supplies with no established fee shall be reimbursed at 130% of invoice cost or such other cost as agreed to by the Plan.

7. **Ambulance or Emergency Care**: Shall be covered in or out-of-network at the same copay. Additionally, all charges will be paid based on the established "network" rate or "allowable charges," as determined above for out-of-network providers in accordance with Section 1302 (4)(E)(i) and (ii) as provided below:

    a. Coverage for emergency department services will be provided without imposing any requirement under the Plan for prior authorization of services or any limitation on coverage when the provider of services does not have a contractual relationship with the Plan for providing services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the Plan; and

    b. If such services are provided out-of-network, the cost sharing requirement (expressed as a co-payment amount or coinsurance rate) is the same requirement that would apply if such services were provided in network.

8. **Emergency Surgery**: Providers will be paid the same as network providers. When payment to out-of-network providers is within the "*prevailing Payor rate"* for a given area, the payment made by the Plan plus the member copay should be accepted as payment in full and the member should not be balance billed for excess charges under the Health Care Reform.

9. **Dental Providers Not Enrolled as Medical Providers are Out-of-network Providers**: Dental PPO providers are considered out-of-network for purposes of any medical services unless they are also in the medical PPO network. Oral Surgeons perform both medical and dental procedures.

10. **Medicare Primary Members**: Allowable charges for Medicare covered expenses are limited to the Medicare allowable charge. For purposes of benefit payment, Medicare providers are treated the same as PPO providers. For charges where there is no established Medicare allowable fee or non-Medicare service, the allowable charge shall be based on the allowable charge under Context^4 Healthcare at the 70th percentile.

IMPORTANT NOTICE TO MEMBERS REGARDING PROVIDER CHOICES

1. Members should NEVER sign an agreement to pay the full provider's bill if the insurance company does not pay. This may obligate you to pay charges that you should not be required to pay. Patients should not be intimidated into signing such a statement at the time of service.

2. **Members are responsible for verifying a provider's PPO status prior to service.** Members who fail to maximize their primary plan benefits by using a provider not covered by their primary plan will receive benefits from this plan based on what this plan would have paid had the primary plan paid its normal benefit. This plan will never pay more than the allowed charges less the primary plan payment.

3. **Charges for some Plan allowances are stated in the Schedule of Benefits**. These include limited benefits such as chiropractic care.

4. **If the Plan negotiates a reduced fee amount** on an individual claim for services or supplies, the covered benefits will be limited to the negotiated amount. Your coinsurance will be based on the reduced fee amount. If you choose to use a provider other than the one we negotiated a reduction with, you may be responsible for the difference in these amounts.

5. **Members should request that providers accept as full payment the plan benefit plus the normal NPPO deductible, copay, and/or coinsurance.** However, the Plan has no control over what a provider's billing practices will be and members should be prepared in advance of the possibility of being responsible for significant extra charges when using an out-of-network hospital or provider, even when they are enrolled Out-of-Area since Out-of-Area members are still responsible for excess charges over the Allowed Charges by this plan.

6. **To estimate our maximum Plan allowance for a non-PPO provider before you receive services from them**, call us at (844) 583-3863. You must first get a detailed estimate from your provider with the procedure codes and charges. It is always advisable when going to an out-of-network provider to ask that provider to accept the Plan payment plus your applicable copay, coinsurance, and deductible as payment in full for his/her services.

7. **If your provider routinely waives your cost** (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived. Please note that not disclosing such an arrangement may be considered a fraudulent act.

   For example, if your physician ordinarily charges $100 for a service but routinely waives your 30% coinsurance, the actual charge is $70. We will pay $49.00 (70% of the actual charge of $70).

8. **Waivers**: In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts the Plan has with its providers. **If you are asked to sign this type of waiver, please be aware, if benefits are denied for the services, you could be legally liable for the related expenses.**

9. **Provider's bill is more than the Plan's allowance/Eligible Charges**: Whether you must pay the difference between our allowance and the bill will depend on the provider you use. Excess charges "may" be balance billed to the member who, in turn, may negotiate a reasonable fee with the provider for final payment. Members should be aware of potential charges and liability if they choose to go out-of-network. The Plan reserves the right to make a reasonable determination based on all facts and circumstances to determine a "reasonable" allowance for the actual cost of any item, supply, or medical equipment outside the PPO Contract and for any inpatient/hospital charges by out-of-network providers.

APPEALS - ADVERSE BENEFIT DETERMINATION

The INTERNAL grievance and appeal procedures are provided to give each member the optimum opportunity to access benefits provided by the Plan.

A comprehensive notice concerning your appeal rights is found in Part C of the Plan. As part of the appeal process, a covered person has the right to the following, upon filing a written request or appeal. In order to fully protect your rights, all appeals should be in writing and follow the procedures set forth in this Section. In lieu of or prior to submitting a formal written appeal, the member may contact the Compliance Office and request a review of a specific claim. All appeals will be handled on an informal basis within 30 days. **In the event the member or provider is not in agreement with the action taken or decision by the Compliance Office, they should proceed with filing a formal written appeal and all relevant documentation should be filed with the appeal.**

1. Review the Plan and other relevant documents;
2. Argue against the denial in writing; and
3. Have a representative act on behalf of the covered person in the appeal.

All relevant documents will be provided free of charge, upon request by the claimant, after receiving an Adverse Benefit Determination. A document, record, or other information is considered relevant if it was

relied upon in making the benefit determination, if it was considered or generated in the course of making the benefit determination, if it demonstrates compliance with the administrative processes, or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the determination.

Adverse Benefit Determination Defined

Under Section 2719 of the Health Care Reform Act and the Interim Final Rules, an adverse benefit determination eligible for internal claims and appeals processed includes a denial, reduction, or termination of, or failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in the Plan;
- A determination that a benefit is not a covered benefit;
- The imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

All Appeals Are Entitled to a Full and Fair Review

A full and fair review of an Adverse Benefit Determination will be performed by an appropriately named fiduciary, who is neither the party who made the initial adverse determination, nor the subordinate of the person. The review will not defer to the initial adverse benefit determination. The review will take into account all comments, documents, records, and other information submitted by the claimant, without regard to whether such information was previously submitted or considered in the initial determination. All evidence considered, relied upon, or generated by the Plan in connection with the claim must be provided to the claimant to provide them with a reasonable opportunity to respond to such denial. The denial must also include a notice of the standard, if any, used in denying claims. For example, a denial based on medical necessity would include the medical necessity standard.

If the review results in another Adverse Benefit Determination, it will include specific reasons for denial, written in a manner understandable to the covered person and will contain specific reference to the pertinent Plan provisions in which the decision was based.

Adverse Benefit Determination Timeframe for Response

If the Claimant/Authorized Representative appeals an Adverse Benefit Determination, the Plan will respond to the appeal within:

- **24 hours for an Urgent Care Claim** *(excluding weekends and holidays*);
- **30-days for a Pre-Service Claim**; or
- **60-days for a Post-Service Claim**. The notice will specify the reason for the denial or describe the additional information required to process the claim. Written denial will include:
    1. Specific reasons for denial with reference to applicable Plan Document provisions;
    2. Description and need for any other material pertinent to the claim; and
    3. An explanation of the Plan's review procedure and the names of any medical professionals consulted as part of the claims process.

The following charts provide a quick overview of the appeal process and are followed by a more detailed description of the various appeal processes. Please see the Notice of Appeal Rights in Part C.

APPEAL CHART	
Who May File an Appeal	Any covered member or a Primary Member on behalf of a covered dependent; or any authorized representative, including a provider on behalf of the patient. All appeals must be filed with the Compliance Office except for Urgent Care Appeals which must be filed with the Pre-certification Department.
Pre-service Claim	Request must be made **within 60 days of a previous denial**. *A response must be provided within 24 hours for an Urgent Care Claim (excluding weekends and holidays) and 30 days for all other pre-service claims.*
Post-Service Claim	All appeals must be filed within 180 days of the initial denial. All post-service claims will be responded to within 30 days unless additional time is required. A response will be sent no later than 60-days from the date of the appeal.
Informal Appeal (optional)	Informal review of any claim based on the Explanation of Benefits (EOB). Any request for review must be made within 180 days of the initial denial. It is recommended that all Appeals be submitted in writing. Verbal requests <u>are not</u> considered to be a "formal" appeal but will be given every possible consideration on a fair and impartial basis to resolve the issue.
Level 1 – Formal Written Appeal	This must be filed **in writing** within 180 days of the initial denial based on the Explanation of Benefits (EOB) date. All details with respect to disputed charges and any extenuating circumstances must be provided either by the member or the provider (or both).
Level 2 – Second Written Appeal on a Previously Denied Claim	**<u>A second appeal must be filed within 45 days of the previous denial</u>**. Once a final Adverse Determination is made, the Internal Appeals Process is deemed exhausted. Members must submit all relevant information and any additional information with each appeal in writing in order to comply with the Internal Appeal Rules. Each appeal will be reviewed as if it were a new appeal, with "fresh eyes" or on a "de novo" (new) basis.
Internal Appeal Process	Initial appeals are handled by the Assistant Compliance Officer. Any appeal of a decision by the Assistant Compliance Officer will be reviewed and a final determination will be made by the Compliance Officer. The decision of the Compliance Officer will be the Final Internal Appeal determination.
Peer Review Process	The Plan reserves the right, as part of its internal review process, to forward any prospective or retrospective claim, request for treatment, or continued treatment when there is a question of "medical necessity," "appropriateness of treatment" or "level of care" or "effectiveness of care" is an issue to an **Independent Review Organization (IRO)** for a **Peer Review**. The Independent Review Organization (IRO) will be completely independent of the Plan and its findings shall be binding on the Plan. The IRO utilized will be staffed by appropriate professionals who are Board Certified in the particular area of medicine involved and a copy of the review notes will be provided to the member and the provider as part of the review process. Whenever an Independent Review has been conducted, the internal claims review process shall be considered to have been exhausted regardless of who requested the initial review. IRO shall be selected by the Plan on a random basis among those IRO available for the presenting condition. **The member, authorized representative or provider is also permitted to request a Peer Review within 60 days following an adverse benefit decision by the Plan of either a pre-service or post-service claim.**

EXTERNAL APPEALS	
Please note there is a $25 filing fee payable upon request of an External Review of a claim.	
External Review by Independent Review Organization (IRO)	Following a final Level 2 denial or requested simultaneously when filing an appeal or provided by the Plan in the event of a dispute based on medical necessity, appropriateness of care, health care setting, level of care or effectiveness of a covered benefit or care. The External Review will be conducted by an Independent Review Organization (IRO) selected by the Plan on a rotating basis to insure an impartial and fair decision that will be binding on the Plan. An external review must be requested within 4 months of the initial denial. **The Plan has elected to engage in private accredited IRO's to handle external appeals.** (1) Generally, a request for an external review may not be made until the internal review process has been exhausted. If our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment, you may submit a request for external review within **4 months** after receipt of the initial denial. An external review may be requested with your initial appeal. (2) Appeals involving medical judgment *(excluding those that involve only contractual or legal interpretation without any use of medical judgment)* as determined by the review, or rescission of coverage. *(Termination due to failure to pay premiums or due to loss of eligibility per plan rules does not constitute a rescission of coverage).* For a standard external review, a decision will be made within **30-days (45-days if additional time is needed or if additional documentation or date is required)** of receipt of your request.
Expedited External Review	If you have a medical, behavioral, or addictive condition that seriously jeopardizes your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental, investigational, or not medically necessary, you may also be entitled to file a request for external review of our denial. If a treatment program is in progress and the Plan denies further treatment without an IRO review, then treatment will continue to be covered until the IRO completes its review and the provider and member are advised of the IRO findings. Both the Plan and the member are required to abide by the decision and findings of the IRO under the Appeal Rules under the Affordable Health Care Act (ACA). If the external review findings are in favor of the claimant, benefits will be covered retrospectively during the review period.
Coverage during the Review Process	If our initial denial of benefits or continued treatment is based on the findings of an Independent Review Organization (IRO), benefits will not be covered during the second appeal process if the provider or member disagrees with the initial decision. If the second IRO opinion is different from the initial IRO a third review will be requested.

Appeal of an IRO Decision under the External Claims Process	The member or provider may appeal an IRO decision once, provided a second review is requested within **30-days** of the initial review and additional information being submitted for review. The second review must be conducted by a different Board-Certified Professional who may be from the same IRO as the first reviewer. The findings of an IRO shall constitute a final decision unless the second review differs from the initial IRO finding. In this situation, a third review shall automatically be requested by the Plan from a separate IRO. The findings of an IRO shall be considered binding on all parties, except to the extent that another remedy is available under Federal law. **Your review or appeal rights, both internally and externally, will be deemed exhausted once the IRO process is finalized.** The fees for all IRO reviews shall be paid by the Plan.
Examples where an external review may be requested	1. The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility); 2. Whether treatment by a specialist is medically necessary or appropriate (pursuant to the Plan's standard for medical necessity or appropriateness); 3. Whether treatment involved ''emergency care'' or ''urgent care'', affecting coverage or the level of coinsurance; 4. A determination that a medical condition is a pre-existing condition; 5. The Plan's general exclusion of an item or service (such as speech therapy), if the Plan covers the item or service in certain circumstances based on a medical condition (such as, to aid in the restoration of speech loss or impairment of speech resulting from a medical condition); 6. Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the Plan's wellness program; 7. The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline 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 its implementing regulations); and 8. Whether a plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.
All Other Appeals *(Not Eligible for External Appeals)*	**Includes appeals not related to medical necessity, appropriateness, health care setting, level of care, or effectiveness of covered benefits or care, such as --** appeals involving eligibility for benefits; nonpayment of a claim; late filing penalties; failure to pre-certify benefits in advance of treatment as required by the Plan; penalties for failure to complete a treatment program; payment as out-of-network instead of in-network or Out-of-Area; payment under coordination of benefit rules or where primary plan's EOB was not submitted with claim, etc.
Claims not received or paid by the plan where no Explanation of Benefits (EOB) or Claim Denial was issued	Claims must be filed within one year of the date of service. Claims not received within one year will not be considered for payment absent extenuating circumstances. All requests for consideration must be submitted in writing to the Compliance Office by the member or provider with all relevant facts and mitigating circumstances within 18 months of the date of service. Late filing penalties apply to these claims, even if approved for payment by the Plan.

Claims where an Explanation of Benefits (EOB) was issued	Any claim disputing how a specific claim or benefit was paid must be filed within 180-days (6-months) from the Explanation of Benefits (EOB) date. **Claims filed after 180-days will not be considered for payment absent extenuating circumstances acceptable at the sole discretion of the Plan.**

APPEAL DEFINITIONS AND TERMINOLOGY

The following definitions have been modified to reflect the new rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act. The rules represent changes, per the Interim Final Rule, issued July 23, 2010, and as further clarified July 26, 2011.

"Adverse Benefit Determination" (as modified PPACA) shall include any of the following, which shall be considered an adverse benefit determination, subject to appeal:

1. A denial, reduction, or termination of, or failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:
    a. A determination of an individual's eligibility to participate in the Plan;
    b. A determination that a benefit is not a covered benefit;
    c. The imposition of a pre-existing condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit; or
    d. A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.
2. A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit can include both pre-service claims (for example, a claim resulting from the application of any utilization review), as well as post-service claims.
3. A failure to make a payment includes any instance when a plan pays less than the total amount of expenses submitted with regard to a claim, including a denial of part of the claim due to plan terms regarding copayments, deductibles, or other cost-sharing requirements.
4. A rescission, cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage, including COBRA premiums.
5. A failure to provide or make a payment (in whole or in part) of a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the Plan.
6. A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

The initial notice of an adverse benefit determination will generally be made by way of the actual claim payment which is summarized on the explanation of benefits (EOB). Remark codes are used to explain any adjustment on the claim. A copy of the EOB is sent to both the provider and the primary member when assignment of benefits is indicated on the claim filed by the provider. If the provider or member needs further explanation of or takes issue with any adjustment, they should file an appeal with the Compliance Office.

An adverse benefit determination includes rescissions of coverage or discontinuance of coverage that has a retroactive effect unless attributable to a failure to timely pay required premiums or contributions toward the cost of coverage, or due to misrepresentation of fraud on the part of the member. It is considered

fraudulent or misrepresentation *(whether intentional or unintentional)* to cover an individual who is not eligible for coverage under the terms of the Plan, or to fail to notify the Plan if there has been a change in status of any covered member, including a change in any other coverage *(either the acquisition of or loss of other coverage)*. Members are responsible for reimbursing the Plan for any claim paid or for COBRA premiums when coverage is extended to covered members beyond the point when they were eligible for coverage under the Plan.

Notification of an adverse benefit determination (*at the initial level and on review)* based on medical necessity, experimental treatment, or other similar exclusion or limit, will be explained as to the scientific or clinical judgment of the Plan to the claimant's medical circumstances, or an explanation will be provided free of charge to the claimant upon request. When the Plan utilizes a specific internal rule or protocol, it will furnish the protocol to the claimant or their authorized representative, upon request.

"Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

"Appeal" means an appeal (or internal appeal) is defined as a review by a plan of an adverse benefit determination, as required under the plan's internal claims and appeals procedures.

"Authorized representative" means:

1) A person to whom a covered person has given express written consent to represent the covered person in an external review;
2) A person authorized by law to provide substituted consent for a covered person; or
3) A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.

The Plan will recognize an authorized representative, including a healthcare provider, acting on behalf of a claimant. The Plan will recognize a healthcare professional with knowledge of a claimant's medical condition as the claimant's representative in connection with an urgent care claim. Procedures will be established by the Plan to verify that a representative has been authorized to act on behalf of a claimant. Members must have a HIPAA authorization on file to permit discussion of confidential information to anyone other than the member or a dependent, who is a minor. Example: Authorization must be on file to permit a member to discuss their spouse's claim.

"Best evidence" means evidence based on:

1) Randomized clinical trials;
2) If randomized clinical trials are not available, cohort studies or case-control studies;
3) If paragraphs (1) and (2) are not available, case-series; or
4) If paragraphs (1), (2) and (3) are not available, expert opinion.

"Case-control study" means a retrospective evaluation of two (2) groups of patients with different outcomes to determine which specific interventions the patients received.

"Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

"Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

"Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

"Claim for Benefits" means a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. A claim for benefits includes any pre-service and

post-service claim. A request for benefits includes a request for coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

"Claimant" means an individual who makes a claim under the rules for internal claims and appeals and external review procedures, and expressly includes a claimant's authorized representative. A claimant includes participants and beneficiaries and may also include the provider.

"Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

"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. Also, voluntary treatment taken on a pre-emptive basis in order to avoid court ordered treatment, civil or criminal penalties are not covered.

Coverage for services is subject to plan limitations, plan design, and should adhere to information that dictates which medically necessary criterion is applicable. All inpatient stays are based on admission criteria, severity of need and intensity of service.

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
3) The most appropriate (supply) or level of care.

"Cohort study" means a prospective evaluation of two (2) groups of patients with only one group of patients receiving a specific intervention(s).

"Concurrent Care" refers to ongoing care or course of treatment.

"Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

"Conflict of Interest and Impartiality of the Compliance Staff" means that all appeals are handled by the Compliance Department. This department operates independently from all other Plan departments. The individuals handling appeals include the designated compliance officer and assistant compliance officer. Claims are adjudicated separately by the claims department; thus, the compliance department is not a party to the actual processing of the initial claim. The compliance staff are not hired, compensated, terminated, promoted, or subject to similar personnel actions based on how they perform the compliance functions on behalf of the plan. Their sole responsibility is to view all the relevant facts and make a decision based on the clinical or medical information provided, taking into account the actual plan language and input from all sources to render an impartial and unbiased decision.

"Covered benefits" or "benefits" mean those health care services to which a covered person is entitled to under the terms of the Plan.

"External Review" means a review of an adverse benefit determination by the State Department of Insurance, or a designated Federal Agency for self-funded plans, and includes a final internal adverse benefit determination under applicable state or federal review procedures. A request for External Review must be filed within four (4) months of the final adverse determination by the Plan.

"Final External Review Decisions" means a final external review decision is a determination by an Independent Review Organization (IRO) at the conclusion of an external review. The decision of an IRO is binding on both the Plan and the claimant.

"Healthcare Professional" means a physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information, and a statement from the attending Physician (if applicable). A written reply will be sent and kept on file.

"Internal Adverse Benefit Determination" means one of the following:

- A final internal adverse benefit determination has been upheld by a plan at the completion of the plan's internal review procedures; or
- An adverse benefit determination for which the internal appeals procedures have been exhausted under the "deemed exhausted" rule as defined by the regulations for Group Health Plans.

"Independent Review Organization (IRO)" refers to an entity that performs independent external reviews of adverse benefit determinations and final internal adverse benefit determinations under state or federal external review procedures. An IRO may also be utilized to provide a peer review as part of the internal review process.

"Instructions for Submission of Claims Appeals" are listed below as to what must be submitted in conjunction with an appeal. If necessary, you may need to follow up with your provider to ensure all required information is submitted. The member is responsible to follow-up on unpaid or past due claims to determine a problem. Make sure bills include all the following when submitted:

1) The employee's name, Member ID number and home address;
2) If claim is made for a dependent, dependent's name, employee name, and age;
3) The name and address of the Physician or Hospital;
4) The physician's diagnosis;
5) An itemization of charges;
6) The date injury or illness occurred; and
7) Drug bills (not cash register receipts) showing Rx number, name of the drug, date prescribed, date filled and the name of the person for whom the drug is prescribed.

- Acceptable Bills/Documents include all the following:
  - HCFA/UB or Super Bills (any submitted claim form with all the following information):
    a. Detail of procedure performed;
    b. Detailed breakdown of charges;
    c. Diagnosis;
    d. Date of service; and
    e. Federal Tax Identification Number (TIN) and the address of the provider.
- **A bill submitted with all the above information included will be processed unless additional information is required to complete a claim. Additional information required could include, but is not limited, to the following:**
  a. Coordination of Benefits, other Insurance Coverage;
  b. COBRA eligibility;
  c. Parental custody;
  d. Legal responsibility for dependent child health coverage;
  e. Separation or divorce decree;
  f. Medicare eligibility;
  g. Full-time student status;

h. Certificate of Creditable Coverage;

i. Medical history information; and

j. Injury or accident information.

When the claims office receives a bill with the required information, it will be processed in accordance with the time frames for post-service claims, pre-service claims, and urgent care claims, with all other plan provisions, and with eligibility and claim information on file. The claims office will provide a notice of benefit determination, or a notice of adverse benefit determination, to the covered person's designated address.

Every attempt will be made to help covered persons understand his/her benefits; however, any statement made by the Trust Office staff or the claims office will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing.

"Loss" refers to covered expenses incurred, disability or accidental death or dismemberment, as provided in the Plan. When a notice of claim is received, the plan sponsor or claims supervisor will send the claimant forms to file a proof of claim. If the form is not provided to the claimant within ten working days, the claimant will meet the proof of claim requirements by giving the plan sponsor or claims supervisor a statement in writing of the nature and extent of the loss. Positive proof of claim must be given to an authorized claim office, for a medical or health insurance claim, as required under this Article. If it was not reasonably possible to give notice and proof in writing in the time required, the plan sponsor or claims supervisor will not reduce or deny the claim if proof is filed as soon as reasonably possible. Otherwise, late-filed claims will be denied.

"Medical Management" refers to a process where the Plan may retain independent medical consulting firms to do a comprehensive claims review to ascertain appropriateness of the coding relationships to the diagnosis codes and reasonableness of fees based on the fees normally charged for the same services in that geographic area. Most out-of-network hospitals and sometimes surgical claims will be selected for review. For a complete explanation of the processes used by the Plan go to the Allowable Section in Part B.

"Medical Necessity" for purposes of mental health, behavioral and addictive conditions is defined as the level of care criteria that follow the guidelines for determining medically necessary treatment based on DSMIV-TR disorders.

"Peer Review (Internal Appeal)" is a review by an independent review organization (IRO) selected by the Plan. This is often referred to as a peer-to-peer review. A specialist will review and/or discuss the treatment plan and protocols directly with the patient's providers as part of the review process to determine medical necessity, and appropriateness of treatment. Peer reviews are used by the Plan to provide independent and fair analysis in complex cases. The cost of any Peer Review is paid by the Plan and shall be binding on the Plan and the member under the Internal Review Process. A request for peer review must be filed within 60 days of an adverse determination by the Plan.

"Pre-Service Claim" is any claim requiring pre-approval (also referred to as pre-certification) prior to the service being provided. When benefits are subject to prior approval, failure to obtain prior approval could result in the claim being denied in whole or in part. Prior approval is the responsibility of the patient and the provider, depending upon the service being provided. **Patients are responsible for obtaining approval and/or ensuring their provider has obtained the necessary approval for any out-of-network services or any outpatient services requiring pre-approval or pre-authorization.**

"Penalties for Failure to File Claims Promptly and Timely" apply. The Plan will not be liable for payment of any claim that is not submitted for payment, as required by the Plan. Claims must be submitted within 90 days of service and appeals, with respect to an unpaid claim, must be filed timely in accordance with this section. In no event will the Plan be responsible for any claim filed more than one year after the date of service. Satisfactory proof of filing to the Plan may be required. Late filing penalties may be assessed based on the penalty chart in Part A.

In no event will claims that were not filed with the claim's supervisor be covered by the Plan unless the Plan is notified in writing of the pending claim and the reason for the delay. For example, there may be delays due to receipt of coordination of benefits or subrogation information. The employee is responsible for making sure that providers promptly submit bills. Members should follow up with providers if a copy of the Explanation of Benefits (EOB) is not received within 30-45 days after service is rendered. The member/employee is responsible for reviewing the explanation of benefits (EOB) and for immediately paying any balance due to the provider. If payment on a claim is in doubt, check it out immediately. **The member is also responsible for ensuring that any provider submitting a bill on their behalf has the proper mailing address. Members should immediately contact the provider when they get a bill stating no benefits have been paid.**

The Plan reserves the right to refuse to pay benefits until ALL requested information is provided, including any agreements dealing with coordination and subrogation issues. All subrogation papers must be timely executed and filed within 60 days of the request (provided the claims were filed timely as required below), for claims to be considered eligible for payment under the Plan. Claims filed after these dates will not be paid, unless there are reasonable circumstances for the delayed filing of the claims, or documentation of prior filing of these claims. A written notice of a medical or health insurance claim must be given within the time limit, as provided in this article, for the Plan to be liable.

All claims should be filed with the claim's supervisor or the PPO, as directed on your ID card. In the review and processing of claims, the claims supervisor may rely on standard operating procedures and guidelines as established by the TPA for similar claims or circumstances for any plans administered.

"Post-Service Claim" means any claim that is not a pre-service claim. (See retrospective review.)

"Pre-Existing Conditions Limitation Requirements" are not applicable to this plan, as this plan has no pre-existing conditions or limitations.

"Reimbursement Rights" means that the covered person, by accepting benefits under the Plan, agrees to hold in constructive trust any money or property resulting from any recovery, insurance payments, settlement proceeds, third party payments, settlement proceeds or judgment for the Plan's benefits under this provision. If a covered person fails to reimburse the Plan for all benefits paid or to be paid, as a result of their Illness or Injury, out of any recovery or reimbursement received, the covered person will be liable for all expenses (fees or costs) associated with the Plan's attempt to recover the money from the covered person. The right of reimbursement will bind the covered person's guardian(s), estate, executor, personal representative, and/or heir(s). See also Subrogation of Benefits Section.

"Retrospective Review" refers to a review that takes place after the service has been provided to determine the appropriateness of services provided, the charges for such services, and whether they were medically necessary. The Plan reserves the right to audit any claim retrospectively, especially a hospital or surgical claim.

"Urgent Care Claim" means any pre-service claim for medical care or treatment with respect to the application of the time period to make non-urgent care determinations could seriously jeopardize the life or health of the claimant, or the ability of the claimant to regain maximum function. Or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A post-service claim is never an urgent care claim.

PRE-SERVICE – APPEAL PROCESS

Internal Appeal of Pre-certification and Medical Necessity (Pre-service Claims)

If your appeal involves the approval of an urgent treatment or procedure immediately, call the Precertification office. This also applies to any post-service request to retrospectively pre-certify a procedure that was not approved prior to treatment. However, the failure to pre-certify may apply. (See penalty chart in Part A.) Complete doctor's notes must be provided with a detailed explanation of why you believe medical necessity criteria were met for care. Copies of the treatment plans (past and proposed) must be submitted with progress notes, prognosis, and diagnosis of the patient's condition.

In the event of a dispute over a pre-service or proposed treatment plan, appropriateness of treatment, or medical necessity of treatment, an appeal for an independent review may be filed in writing directly to the Compliance Office, including a second appeal of a previous ruling on medical necessity. **Any appeal must be made within 60 days of the initial pre-certification denial.** Only after a final adverse determination is made via the Internal Appeal Process may a request for an Independent Review be made.

Pre- and Post-Service Claims (Non-Urgent Care Claims)

Pre-Service claims must be decided within a maximum of 15 days at the initial level and up to 30 days following an adverse benefit determination. In the case of failure by a provider, claimant, or an authorized representative of a claimant, to follow the Plan's procedures for filing a Pre-Service Claim, the claimant or representative will be notified of the failure and the proper procedures to be followed to file a claim for benefits. Notification will be provided as soon as possible to the Claimant or Authorized Representative, as appropriate, as soon as possible, but no later than five (5) days following the failure. Notification may be oral unless the claimant or authorized representative requests written notification.

Post-Service claims must be decided within 30-days for the initial decision and a maximum of 60-days to review. See Internal Appeals – Post-Service Claims below.

Urgent Care Claims

Determination for Urgent Care Claims (whether adverse or not) must take place as soon as possible but no longer than **24 hours (**excluding weekends) following receipt of all required clinical information. The Plan will notify the claimant as soon as possible, but no later than 24 hours after receipt of the claim by the Plan of the specific information necessary to complete the claim. The claimant will be afforded a reasonable amount of time, considering the circumstances, but not less than 48 hours, to provide the required information. The Plan will notify the claimant of the plan's benefit determination, whether adverse or not, as soon as possible, but no later than 24 hours after the earlier of:

a. The Plan's receipt of the specified information; or

b. The end of the period afforded the claimant to provide the additional information.

c. Urgent care claims must be decided within 24 hours (excluding weekends and holidays) following receipt of the clinical information. In the event of treatment over a weekend or on a holiday, such information will be reviewed retrospectively.

If an individual is receiving an ongoing course of treatment, treatment shall continue to be covered during the appeal process until a decision is made by an Internal Review Organization (IRO). Treatment will not be covered if this is a second appeal with additional documentation of a previous denial based on the findings of an Internal Review Organization (IRO).

Request for Independent Peer Review

A member may request a peer review by an Independent Review Organization (IRO) within 60-days of any adverse benefit determination for a pre-service claim based on medical necessity, appropriateness of care, care setting, level of care, or effectiveness of covered benefits or care. The IRO will be selected by the Plan from a pool of IRO's on a rotating basis. A Board-Certified Physician or Specialist will conduct a peer review and the plan will be bound by any decision.

The member has the right to request an External Review or Expedited External Review by an Independent Review Organization (IRO) within 4 months of a final adverse determination or denial due to medical necessity directly from the plan – see B-7.

INTERNAL APPEALS – POST-SERVICE CLAIMS

Benefit Payment Appeals (Post-Service Claims)

You will be notified in writing if benefits are reduced by way of the explanation of benefits (EOB), which is always issued to the primary member and to the provider if an assignment of benefits is on file or the claim was filed by the provider. All appeals must be submitted in writing as provided by the Plan. (Please

refer to Part A for contact information under Important Numbers to file all appeals.) You may appeal a decision in writing within 180-days of a benefit reduction or claim denial, if:

1. You believe extenuating circumstances prevented you from complying with the pre-certification and utilization management requirements;
2. You followed the doctor's recommendation even though it was contrary to the utilization management's opinion as to the type of care;
3. You believe that utilization management reduced benefits incorrectly; or
4. You believe the benefit was paid incorrectly or was not paid in accordance with the Plan.

In the case of a claim that was never received by the Plan for payment, no consideration will be given to claims that are received more than one year after the date of service. The Plan will review claims up to 18 months after the date of service upon receipt of documentation of reasonable cause. All decisions of the Plan will be considered final. **It is the responsibility of the provider and the member to follow up on a frequent basis (every 30 to 60 days) on unpaid claims**.

Any appeal submitted more than six (6) months after the initial claim has been processed by the Plan may be denied in full. Any claim that is reconsidered, due to extenuating circumstances, will be subject to the limits and penalties, as provided below, including claims when the required pre-certification or pre-approval rules were not followed, and retrospective review is requested. **The 180-day period shall not extend your appeal rights with respect to either internal or external claims.**

Internal Appeal Levels (Post-Service Claims)

The Plan has a separate Compliance Office to review all appeals, complaints, and questions on plan interpretation. To protect your rights, HIPAA requires that you file an appeal no later than 180-days following a denial, the issuance of an Explanation of Benefits (EOB) denying benefits, or a failure to pay benefits per the Plan, in the opinion of the member or the provider. The Compliance Office will make every effort to resolve your complaint via phone call, fax, e-mail, or by letter.

You must submit your grievance, complaint, or appeal in writing to fully protect your rights. You may also designate an authorized representative, including your provider, to file an appeal on your behalf. Providers are also entitled to file an appeal in conjunction with any claim where assignment of benefits applies.

Investigation of Payment and/or Benefits – Informal Inquiry-Request

Contact the Compliance Office regarding routine questions on how a claim was paid or for claim status. The claims supervisor accepts any claim for benefits made in the manner provided by the Plan and, after investigation and verification of the statements contained in the application, determines the eligibility of the participant for benefits. If the facts stated in the application are determined, upon investigation by the claims supervisor to entitle the participant to receive payment of benefits or additional benefits from the Plan, the claims supervisor will adjudicate the proper payment from the Plan. All claims paid under the Plan will be paid in a uniform, consistent and nondiscriminatory manner. No claims will be paid outside the Plan rules unless written directions from the Compliance Officer or the Plan Sponsor is received.

If you disagree with how a claim is paid, you should contact the Compliance Office to review the claim and for reconsideration. Reviews will generally be done on an informal basis if the matter can be resolved in favor of the member or provider. If the decision is an adverse decision or a denial, a written response will generally be provided within 30 days and no later than 60 days, if additional information or research is required before a final decision can be reached.

Level 1: Complaints and Appeals (Formal Written Appeal)

The Plan requires a separate written appeal filed for each claim related to a specific treatment period, to a provider or date of service, or in the case of a provider a separate appeal is required for each claimant. A specific appeal form is not required. The initial notice of denial will be noted on the Explanation of Benefits (EOB) form in the remarks area or via other written notice that gives the employee the additional information necessary to permit the claim to be processed, if appropriate. If the claimant or provider

disagrees with the way a claim is paid, it must be appealed in writing. Only claims filed and received by the claims department will receive an Explanation of Benefits (EOB). An EOB will be sent to both the provider and the member for claims filed by the provider when there is an assignment of benefits. Otherwise, the EOB will only go to the member when the reimbursement is being made to the member. **The provider and the member are both responsible for timely following up on unpaid claims at least every 60 days**.

A claimant can:

1. Request a review of the decision by written application to the Compliance Office for the Plan no later than 180-days after receipt by the claimant of written notification of denial;
2. Review pertinent documents;
3. Submit issues and comments in writing;
4. Have a representative act on a claimant's behalf in the appeal; and
5. The appeal should include any additional facts or information to aid in the review process. A second or subsequent appeal may be made, only if there are additional facts not presented in the initial appeal. To protect your appeal rights, the claimant, provider, or member, as appropriate, must provide a written response with the requested information.

Level 2: A Second Appeal for a Previously Denied Claim

The appeal must be filed within 45 days following receipt of the original denial unless special circumstances require an extension for processing. All level 2 Appeals must be in writing and directed specifically to the Compliance Office. If extended time is needed, a decision will be rendered within a reasonable period of time but no later than 60 days after receipt of the request. The decision for review will be in writing and include the specific reason(s) for the decision and specific reference(s) to the pertinent policy provisions on which the decision was based. Nothing provided in the above claim procedures will modify or amend other claim provisions set out in the Plan. The Compliance Office has the authority to interpret the Plan in a nondiscriminatory manner utilizing all available information. The Compliance Office operates independently from the claims office and pre-certification department and is not involved in the initial denial. It is the specific responsibility of the Compliance Office to take into consideration all the facts from each department and to render an equitable decision based on the Plan language and internal policies and procedures.

In the event of an adverse determination, benefit or coverage based on the treatment plan, appropriateness of treatment, or medical necessity of treatment, the member may request that Peer Review by an Independent Review Organization (IRO). A peer review is limited to 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 benefits or care.

Any decision by the Plan will be final and binding to all parties insofar as the internal review process. However, the plan administrator, at its sole discretion, may reopen any claim for further review, and may act, without prejudice, in determining payment or denial with respect to such claim upon reopening the claim. Upon a final ruling at this level or based on a review by an independent review organization, the internal claims process shall be deemed exhausted. The member still has the right to request an external review or expedited external review based on final rules for self-funded plans to be issued. An External Appeal must be filed within 4 months of a final adverse determination by the Plan.

EXTERNAL APPEALS

External or expedited external review is provided for 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 or care. The member has the right to request an external review or expedited external review within 4 months after receipt of a denial.

External appeals must be filed with the NY State Department of Insurance or with the Federal Agency under rules to be issued, which will be incorporated herein by reference. The member and Plan will be bound by the results and findings of an Independent Review Organization (IRO) selected by the state or federal agency responsible for external review process for the Plan.

The Plan offers members an opportunity to request an independent and impartial appeal under the internal peer review procedures for adverse benefit determinations or denials involving medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefits or care. A request for peer review may also be made by the Plan and a second peer review may be requested by the member or provider upon written submission of additional information. Once a final determination is made under the internal appeals process, the request for an external appeal must be made by the member. For additional information, please contact the Compliance Office for assistance or filing information.

COVERAGE DURING APPEAL PROCESS

If the initial denial of a benefit or continued treatment is based on the findings of an Independent Review Organization (IRO), benefits will not be covered during the second appeal process if the provider or member disagrees with the initial decision. If a treatment program is in progress and the Plan denies further treatment without an IRO review, treatment will continue to be covered until the IRO is completed and the provider and member are advised of the IRO findings. The Plan will abide by the decision and findings of the IRO.

The member or provider is permitted to appeal a peer decision once, provided a second review is requested within **30 days** of the initial review. The second review must be conducted by a different board-certified professional who may be from the same IRO as the first reviewer. The findings of an IRO shall constitute a final decision unless the second review differs from the initial IRO finding. In this situation, a third review shall automatically be requested by the Plan from a separate IRO. The findings of an IRO shall be considered binding on all parties, except to the extent another remedy is available under Federal law. **Your review or internal appeal rights will be deemed exhausted once the Internal Peer review process is finalized and you may then request an external appeal.** The fees for all IRO reviews will be paid by the Plan.

The Plan reserves the right to request an independent review to determine whether continued treatment meets the Plan's requirements for medical necessity. The Plan will adhere to the findings of an independent peer review. The provider, primary member, covered member or authorized representative may appeal the decision and request a second review. If the findings of the second review are not consistent with the first independent review, a third review will automatically be requested. If two of the three reviews are in favor of the appeal, any treatment rendered during the appeal period will be covered. If two of the three reviews find that medical necessity criteria have not been met, no benefit will be provided following the initial decision.

Expedited External Review

If you have a medical, behavioral, or addictive condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of a denial. If the denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental, or investigational, or not medically necessary, you may also be entitled to file a request for external review of the denial.

If the Plan has denied your request for the provision of payment for a health care service or course of treatment, continued stay, or health care service for which the covered person received emergency services and has not been discharged from a facility, you have the right to request an expedited external review after July 1, 2011. The claimant is permitted to submit in writing any additional information that should be considered by the peer review organization.

Independent External Review

If the Plan determines medical necessity has not been met, that is when the condition cannot be favorably changed, and when demonstrable improvement has not been documented, an independent review may be

requested. If the Plan issues a final adverse decision involving making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested, you may submit a request for External Review within **4 months after July 1, 2011, per the procedures under B-7.**

COORDINATION OF BENEFITS

Introduction, Coordination of the Plan Benefits with Other Benefits

It is important to remember that **Plan** language will govern **FIRST.** If the Plan language is different between two plans covering the same person, primary and secondary coverage will be determined by using the current NAIC rules, as modified October 2013 and as summarized below.

A contract that provides healthcare benefits and issued before the effective date of this regulation will be brought into compliance with this regulation by the later of:

1. The next anniversary date or renewal date of the contract;
2. 12 months following the date the regulation is adopted by the states; or
3. The expiration of any applicable collectively bargained contract pursuant to when it was written.

For the transition period between the adoption of this regulation and the time frame when plans are in compliance, a plan subject to prior COB requirements will not be considered a non-complying plan by a plan subject to new COB requirements. If there is conflict between the prior COB requirements, under the prior regulation and the new COB requirements, under the amended regulation, the prior COB requirements apply.

Coordination Defined

The coordination of benefits (COB) provision applies when a claimant has health insurance coverage under more than one **plan,** as defined below. Benefit determination rules govern the order each **plan** will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits per its policy terms without regard to the possibility another **plan** may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plan benefits do not exceed 100% of the total **allowable expense**.

COB Definitions

"Plan" includes:

1. Group and non-group insurance contracts and subscriber contracts;
2. Uninsured arrangements of group or group-type coverage;
3. Group and non-group coverage through closed panel plans;
4. Group-type contracts;
5. The medical care components of long-term care contracts, such as skilled nursing care;
6. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts;
7. Medicare or any other governmental benefits, as permitted by law, except as provided in a state plan under Medicaid. That part of the definition of Plan may be limited to the hospital, medical and surgical benefits of the governmental program; and;
8. Group and non-group insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

"Plan" does not include:

1. Hospital indemnity coverage or other fixed indemnity coverage;

2. Accident-only coverage;
3. Specific disease or accident coverage;
4. Limited benefit health coverage as defined by state law;
5. School accident-type coverage;
6. Benefits for non-medical components of long-term care policies;
7. Supplemental Medicare policies;
8. A state plan under Medicaid; and
9. Coverage under any other federal government plan, unless permitted by law.

Each contract for coverage is a separate plan. If the Plan has two (2) parts, COB rules apply to only one of the parts; each part is treated as a separate plan.

The Plan means, in a **COB** provision, the part of the contract that applies healthcare benefits that could be reduced because of benefits under another plan. Any other part of the contract that provides healthcare benefits is separate from the Plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating with similar benefits, and may apply another COB provision to coordinate other benefits.

"Order of Benefit Determination": The rules that determine whether the Plan is a primary plan or a secondary plan when the claimant has healthcare coverage under more than one plan. When the plan is a primary plan, it determines payment for its benefits first before any other plan without considering the other plan's benefits. When the plan is a secondary plan, it determines its benefits after the other plan and may reduce the benefits it pays so all plan benefits do not exceed 100% of the total allowable expense.

"Allowable Expense": A healthcare service or expense that includes deductibles, coinsurance, and co-payments, and is covered at least in part by any plan that covers the claimant. When a plan provides benefits in the form of a service, like an HMO, the reasonable cash value of each service is considered an allowable expense and a paid benefit. An expense or healthcare service not covered by any plan that covers the claimant is not an allowable expense. For COB rules, the following are examples of expenses or services that <u>are not</u> allowable expenses:

1. The difference in cost between a semi-private hospital room and a private hospital room. The claimant's stay in a private hospital room is medically necessary in terms of generally accepted medical practice or one of the plans routinely provides coverage for hospital private rooms. This is not an allowable expense.
2. If a claimant is covered by two (2) or more plans that compute benefit payments on the basis of usual and customary fees, relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the <u>highest</u> of the usual and customary fees for a specific benefit is not an allowable expense.
3. If a claimant is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the <u>highest</u> of the negotiated fees <u>is not</u> an allowable expense. If Medicare is primary, the allowable charge is limited to the allowable fee under Medicare unless the Plan specifically provides otherwise. Medicare is treated the same as a PPO Provider.
4. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a negotiated fee or payment amount that is different from the primary plan's payment arrangement and, if the provider's contract permits, the negotiated fee or payment will be the allowable expense used by the secondary plan to determine its benefits.

5. The amount of benefit reduction by the primary plan **because** the claimant failed to comply with the Plan provisions, is not an allowable expense. Examples of these plan provisions include second surgical opinions, pre-certification of admissions, and preferred provider arrangements.

6. **Closed panel plan**: A plan that provides healthcare benefits to covered persons, primarily in the form of services through a panel of providers that has contracted with or is employed by the Plan and limits or excludes coverage for services provided by other providers, except in case of emergency or referral by a panel member.

"Custodial Parent": The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

ORDER OF BENEFIT (COORDINATION OF BENENFIT) DETERMINATION RULES

If a claimant has health coverage under two (2) or more plans, the rules for determining the order of payment of benefits are as follows:

1. The primary plan pays or provides its benefits per its terms of coverage without regard to the benefits under another plan.

2. The following provisions always control, except:

   a. As stated in the following paragraph below, a plan that does not provide a coordination of benefits provision consistent with this regulation and is primary, unless the provisions of both plans state the complying plan, is the primary plan.

   b. Coverage obtained by virtue of membership in a group designed to supplement part of a basic package of benefits and provides that supplementary coverage is excess to any other part of the plan provided by the contract holder. An example of this type of situation: major-medical coverage that is superimposed over a base hospital plan and surgical benefits and insurance-type coverage written in conjunction with a closed panel plan to provide out-of-network benefits.

A plan may consider benefits paid or provided by another plan to calculate payment of its benefits when it is secondary to the other plan. **(Clarification for the KTF Plan: In the case of a closed panel plan, or when Medicare is the primary plan to the KTF Plan, KTF's benefits will be limited, as provided by the Plan, whenever a member fails to use a covered provider under his/her Primary Plan. Special COB rules apply to members when Medicare is the primary plan.)**

Plan determines its order of benefits using the **first** of the following rules that apply:

1. **Non-Dependent or Dependent Rule**: The plan that covers the person (*not as a dependent)*, for example: an employee, member, policyholder, subscriber, or retiree is the primary plan, and the plan that covers the person as a dependent is the secondary plan.

2. **Exception to the Non-Dependent/Dependent Rule**: If the person is a Medicare beneficiary and, as a result of federal law, Medicare is the secondary plan to the plan covering the person as a dependent, or it is the primary plan to the plan covering the claimant who is not a dependent *(a retired employee or inactive employee),* the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, retiree, or inactive employee is the secondary plan and the other plan is the primary plan.

   The effect of these rules in the case of a retiree covered by Medicare, who is also covered as a dependent under an actively employed spouse, the dependent coverage pays first as the primary plan, Medicare pays second and the non-dependent coverage (e.g., retiree coverage) pays third.

3. **Active Employee, Retired, or Laid-off Employee**: The plan that covers a person as an active employee (an employee who is not laid-off or retired) is the primary plan**.** The plan that covers the same person as a retired or laid-off person is the secondary plan. The same is true if the person is a dependent of an active employee and the same person is also a dependent of a retired or laid-off

employee. If the other plan does not have this rule and the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if rule #1 above (Non-Dependent versus Dependent rule) determines the order of benefits. (This rule does not apply when a person is covered under his/her own plan as an active employee, retired employee, or laid-off employee and is also a dependent under his/her spouse's plan provided to the spouse on the basis of active employment). In this situation, the Non-Dependent/Dependent rule applies.

4. **Dependent Child Covered Under More Than One Plan**: If a dependent child is covered by more than one plan, the order of benefits is determined as follows:

   a. A dependent child whose parents are married or are living together, whether they have ever been married:

      i. The plan of the parent whose birthday falls earliest in the calendar year *(without regard to the year of birth)* is the Primary Plan; or

      ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

   b. A dependent child whose parents are divorced or separated, or not living together, whether they have ever been married:

      i. If a court decree states, one of the parents is responsible for the dependent child's healthcare expenses or health insurance coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to the plan years after the plan is provided notice of the court decree.

      ii. If a court decree states both parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph will determine the order of benefits.

      iii. If there is no court decree allocating responsibility for the dependent child's healthcare expenses or health insurance coverage, the order of benefits for the child is as follows:

         1. The plan covering the **custodial parent**;

         2. The plan covering the spouse of the **custodial parent**;

         3. The plan covering the **non-custodial parent**; and/or

         4. The plan covering the spouse of the **non-custodial parent**.

   c. A dependent child covered under more than one plan by individuals, who are not the parents of the child, the provisions of Subparagraph (a) or (b) above will determine the order of benefits, as if the individuals were the parents of the child.

   d.

      i. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph (6) applies.

      ii. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

5. **COBRA or State Continuation Coverage**: If a person's coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree, or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan. COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does

not have this rule, and the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled non-dependent or dependent rule can determine the order of benefits.

6. **Longer or Shorter Length of Coverage**:

    a. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

    b. To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.

    c. The start of a new plan does not include:

        i. A change in the amount or scope of a plan's benefits;

        ii. A change in the entity that pays, provides, or administers the plan's benefits; or

        iii. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

    d. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

If the preceding rules do not determine the primary plan, the allowable expenses will be shared equally between the plan**s** meeting the definition of **plan.** In addition, the Plan will not pay more than it would have paid if it were the primary plan.

Effect of COB on the Benefits of the Plan

When the Plan is a secondary plan, it may reduce benefits, so the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. To determine the amount paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply the calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan can reduce its payment by that amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan will credit to its plan's deductible any amounts it would have credited to its deductible, in the absence of other healthcare coverage.

1. Determine its obligation to pay or provide benefits under the terms of its contract;
2. Determine whether a benefit reserve has been recorded for the covered person; or
3. Determine whether there are any unpaid allowable expenses during the claim determination period.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not paid by one closed panel plan, COB will not apply between that plan and another closed panel plan.

Right to Receive and Release Needed COB Information

Certain facts about healthcare coverage and services are required to apply COB rules and to determine benefits paid under the Plan and other plans. The Compliance Office and/or the Claims Office may get the facts it needs from or give them to other persons for the purpose of applying the rules and determining benefits paid under the Plan and other plans that cover individual claim benefits. The Compliance Office is

responsible for determining the order of payment under the COB rules for the Plan. The Compliance Office does not need to tell or get the consent of any person. Each person who claims benefits under the Plan must give the Compliance Office and/or Claims Office any facts it needs to apply the rules and to determine payable benefits.

Facility of Payment/Right of Recovery

A payment made under another plan could include an amount that should have been paid under the Plan. If it does, the KTF Plan can pay or reimburse the amount to the organization that made the payment. The amount will be treated as though it were a benefit paid under the Plan. There will be no responsibility for the KTF Plan to pay the amount again. The term *"payment made"* includes providing benefits in the form of services. "*Payment made*" means the reasonable cash value of benefits provided in the form of services.

Right of Recovery by the Plan

If the amount of payment made by the Plan, is more than "it should have paid" under the COB provision, it has the right to recover any overpayment from one or more of the persons it has paid, for whom it has paid, or any other person or organization that is responsible for the benefit or service provided for the covered person. The "amount of the payment made" includes reasonable cash value of any benefits provided in the form of services.

Coordination of Benefit Rules for Rx and Deminis Copays

In the event another plan is the primary plan and Rx coverage is provided under that plan, the benefits under that plan must be exhausted and used to the maximum extent available, prior to primary benefits being paid under this Plan. Members are responsible for knowing which coverage is primary and which coverage is secondary for Rx and medical, the coverage may not be the same. Members are responsible for informing his/her providers and pharmacies which coverage is primary and which coverage is secondary in all situations.

> Example: If a member's spouse is covered under his/her own plan, the member cannot selectively choose to use the KTF Plan for Rx coverage or vice-versa. If a retired member is covered by his/her spouse's plan, his/her retiree's coverage is the primary plan. The retiree's plan must first pay both medical and Rx benefits.

Reimbursement Procedures When This Plan is Secondary for Rx

When this Plan is the secondary plan, you must submit your Rx receipt with your copay amount to the Claims Office. Only copays that are in excess of the deminis copay, specified in Part A, are subject to coordination of benefits. If your copay for a single prescription exceeds the deminis copay under the primary plan, this Plan (secondary plan) will reimburse 80% of your total out-of-pocket expenses (including the copay) until you reach your out-of-pocket limit, then 100% thereafter. When this Plan pays Rx expenses as a secondary payor, they are treated as major-medical expenses and subject to the lowest medical out-of-pocket limit.

Examples of Rx Coordination

The primary plan has a maximum Rx benefit of $1,500/year and this Plan is the secondary plan. If all your Rx copays are less than $10 (deminis copay), there is no reimbursement under COB by this Plan. Once you reach the maximum Rx benefit under the primary plan, all Rx charges will be reimbursed at 80% until you reach your out-of-pocket expense on the claims.

If your copay is less than this Plan's deminis copay under your primary plan, no reimbursement will be made by this Plan. If the Rx copay exceeds this Plan's deminis copay, this Plan will then reimburse your out-of-pocket expenses at 80%.

> Example 1: Rx copay is $40. KTF will reimburse $32 (80%) of the $40. The $32 is paid as a major-medical expense and is not subject to the Rx OOP limit.
>
> Example 2: Rx copay is $10. KTF will not reimburse because $8 (80%) of the $10 is under the $10 deminis copay. The reimbursement will not be made even if you have met your out-of-pocket limit.

Special Rules for Medicare Coordination

The Plan is intended to provide secondary coverage to supplement Medicare and to cover expenses not covered by Medicare, once Medicare is primary, for the covered member, and/or member's spouse, or dependent. Plan benefits will be limited under COB rules depending on the type of provider used and services provided, which will fall in one of the following five (5) categories. In no event will the total amount paid exceed the allowable charges. This Plan's allowed charges will be based on the greater of the allowable charges by Medicare, or this Plan's contractual rates and benefits will be determined based on the following, after taking into account normal deductibles, copays, or coinsurance. For additional information on Medicare Coordination of Benefits rules, you may order this booklet from Medicare, or it is available online: ***Medicare and Other Health Benefits: Your Guide to Who Pays First.*** You may also request a copy from the Compliance Office.

Important Notice: This provision applies to all health expense benefits under the Plan. Coordination with Medicare will apply to all persons eligible for primary Medicare coverage regardless of whether the person is actually enrolled in Medicare. Any employee becomes eligible for Medicare once he/she is no longer actively employed and has attained age 65, unless entitled to earlier coverage due to end-stage renal failure or disability. If a member is not enrolled for primary Medicare coverage, Medicare benefits will be "presumed" and "estimated" for the purpose of determining this Plan's benefits. No payment will be made to any member who is enrolled for primary coverage under a Medicare-sponsored HMO or PPO Plan. If HMO or PPO benefits are denied, due to failure in following HMO procedures for coverage, the Plan will be considered secondary for any member who is enrolled in an HMO or PPO Medicare Plan. Benefits will be limited for any out-of-network provider services. See special Medicare COB rules below.

Category 1: Services Provided by a Provider Who Accepts Medicare Assignment of Benefits

This Plan will pay the difference between what is covered by Medicare and the allowable charges after taking into account normal Plan deductibles, copays, or coinsurance.

Category 2: Medicare Providers Who Do Not Accept Assignment of Benefits

Special rules under Medicare allow providers to charge up to 15% more than what is otherwise allowed by Medicare. These providers require the patient to pay them directly and the patient will then be reimbursed by Medicare. The Provider will bill Medicare. Generally, they will not bill the secondary insurance. This is the responsibility of the members.

> Example: Medicare's allowed charge is $100; the provider may charge $115. In this case, Medicare would pay $80. If this Plan is the secondary or tertiary plan, the maximum allowable benefit paid for these providers is limited to 35% for medical services and 65% for behavioral services, after taking the normal plan deductibles, copays, and coinsurance. This Plan would then pay a maximum of 35%, after the normal plan deductible, coinsurance, or deductible.

Category 3: Contract Providers Not Covered by Medicare

The maximum benefit paid to Medicare Primary Members who elect to use a contract provider. The maximum benefit paid by this Plan is 35% *(65% for behavioral services only).* A contract provider for purposes of this section refers to providers who refuse to accept a Medicare assignment or to bill Medicare; thus, Medicare does not cover any services provided by these providers. The term also includes any providers or services in a situation when the member elects to be covered by a non-traditional Medicare Plan (Regional HMO or PPO Plan).

Category 4: Benefits Not Covered by Medicare

The Plan will pay the same benefits it would pay as if it were the primary plan.

Category 5: End Stage Renal Disease (ESRD):

Any group health plan is primary for the first 30-months after a member goes on dialysis or is diagnosed with ERSD. This rule applies regardless of the employment status of the primary member or the number of employees of the sponsoring employer. For additional information see the publication, ***Medicare and Other Health Benefits: Your Guide to Who Pays First***.

REDUCED BENEFITS FOR FAILURE TO USE PRIMARY PLAN FIRST

If a member or dependent has primary coverage under another plan (such as an HMO), and that plan fails to pay benefits because of a member's refusal to use that plan's providers, benefits under the Plan will be limited to the maximum benefit, as provided under the General Provisions Section and Coordination of Benefit rules. The Plan, as the secondary plan, will be primary only with respect to benefits not covered or available under the primary plan, or when the member has reached the maximum limit under the primary plan, otherwise benefits under the Plan will be limited.

When another plan is the primary plan, the Plan will follow COB rules, similar to those that apply to members covered by Medicare. If another plan is the primary plan for any member or dependent, the benefits under the Plan will be limited to the least of the following:

1. Any benefits, normally covered by the primary plan in or out–of-network, the Plan's benefits will be limited to the maximum benefit that would have been paid if the primary plan paid their portion of the benefit in full. It is assumed an HMO will cover benefits at 100% and a PPO plan will cover benefits at 80% if no documentation is available. The plan's benefits will be computed and then offset or reduced by what would have or should have been paid by the primary plan.
2. If any member or covered dependent of the member voluntarily chooses not to use PRIMARY providers and services and instead uses the services of the Plan, the maximum benefits paid under the Plan will be limited to 50% of all covered charges, subject to a deductible of $500, with an out-of-pocket limit of $10,000. The member will be responsible for all excess charges.

The limits in one (1) and two (2) above will be ignored for any services specifically excluded from coverage under the PRIMARY plan. A copy of the PRIMARY booklet must be provided to the compliance office for review, prior to payment of benefits. The Plan will pay benefits as if the plan is the primary plan.

Example: PRIMARY plan does not cover chiropractic. Chiropractic is covered under the Plan the same as for any other member when the Plan is primary coverage.

DEFINITION OF PLAN TERMS AND EXCLUSIONS

The following definitions have specific meanings for the Plan, which may limit or exclude certain benefits or charges from being covered in addition to specific exclusions under the Schedule of Benefits. These definitions will be used for purposes of this Plan unless the context of the Plan clearly provides a different definition. Any benefits specifically provided for in the Schedule of Benefits will supersede the limitations in this section. The capitalization or lack thereof will not necessarily change the meaning of a term. Singular may be interpreted as plural where appropriate, male versus female, etc.

In addition to the Definitions and Exclusions below, also refer to the Appeals Definitions and Terminology and the Uniform Glossary of Terms as required by the Affordable Care Act, which can be found at www.ktftrustfund.com or a copy may be requested from the Compliance Office.

Accident: An unforeseen event involving an external cause that results in bodily injury (e.g., a fall, an auto accident, etc.). Any accident involving biting or chewing will be covered as a dental benefit only if dental benefits are provided under the Plan. Otherwise, biting and chewing accidents will not be covered as a medical benefit.

Acronyms: Commonly used health and welfare plan abbreviations, listed in Exhibit A.

Adverse Claim: See Appeal Rules in Part B of the Plan**.**

Addictive Disorder: An addictive disorder includes any behavioral disorder that is caused directly or indirectly by an addiction to drugs (legal or illegal) or alcohol. Addictive treatment will not be covered, except as specifically provided in the Addictive Schedule of Benefits, subject to the rules governing Behavioral Treatment, including Pre-certification of treatment. All providers other than BHS providers are paid as out-of-network providers.

Allowable Charges or Eligible Expense: Please refer to Part B for a complete summary of Allowable Charges and how they are determined for in network and Out-of-network providers. Allowable charges are those charges considered by the Plan for purposes of benefit payment. You may be responsible for excess charges if you use an out-of-network provider.

Ambulatory Surgical Facility: A medical facility that is licensed and defined by the laws of the jurisdiction in which it is located. If the law in that jurisdiction does not mandate the definition and licensing of such a facility, then the facility must meet all the following criteria:

1. It is established, equipped, and operated in accordance with the applicable laws in the jurisdiction in which it is located primarily for the purpose of performing surgical procedures.
2. It is operated under the supervision of a licensed Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who devotes full-time to the supervision.
3. It permits a surgical procedure to be performed by a duly qualified physician only who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital (as defined) in the area.
4. It is required in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administers the anesthetics and remains present throughout the surgical procedure.
5. It provides at least two operating rooms and at least one post-anesthesia recovery room.
6. It is equipped to perform diagnostic x-ray and laboratory examinations and has available trained personnel and the necessary equipment to handle foreseeable emergencies, including, but not limited to, a defibrillator, a tracheotomy set and a blood bank or other blood supply.
7. It provides the full-time services of one or more registered graduate nurses (RN) for patient care in the operating rooms and in the post-anesthesia recovery room.
8. It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications or require postoperative confinement.
9. It maintains a medical record for each patient, admitted diagnosis including, for all patients, except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or x-rays, an operative report, and a discharge summary.

Anesthesia: Limited to professional services provided in a hospital, skilled nursing center, ambulatory surgical center, or provider's office. Anesthesia and/or hospitalization for a dental procedure are not covered unless a non-dental physical impairment exists that makes hospitalization medically necessary to safeguard the patient.

Any Other Benefit: For purposes of the Plan, "any other benefit" is the benefit payable under the Schedule of Benefits for procedures/services that are medically necessary and are not specifically excluded or otherwise limited under the terms of the Plan.

Artificial Aids (Orthotics/Prosthetics/Braces): Charges for prosthetic devices and the fitting thereof, include hearing aids, examinations, fittings, and dental orthotics, are not covered except as provided below:

1. Wigs and/or hairpieces are not covered, except in the case of hair loss due to chemotherapy, radiation, or other medical treatment. If a medical treatment results in or will result in hair loss, wigs will be covered up to the maximum as provided in the schedule of benefits. Wigs are not covered for normal loss of hair, baldness, or any other condition. The loss of hair must be due to the "medical treatment" in conjunction with a covered illness.
2. Prosthetic devices, artificial limbs, or orthotic devices will be covered as "any other benefit," to include the fitting thereof, for braces or artificial limbs for a leg, arm, back, or neck. Replacement of orthotics will be covered if there is sufficient change in the covered person's physical condition to make the original device no longer functional or in the event the original device is broken or otherwise not functional. Replacement due to abuse, loss or theft is not covered.

3. Special bras for women who have had a mastectomy will be covered as "any other benefit," up to two (2) bras every six (6) months. Benefits are not payable for duplicate aids.
4. Ostomy supplies specific to an Ostomy cure as medically necessary and per the Ostomy, location, and construction.
5. Exclusions: The following devices are not covered, unless there is a specific provision or benefit in the Schedule of Benefits in Part A of this Plan: Hearing aids, computers, communication devices, cosmetic devices, dentures, or other devices used in conjunction with teeth, Temporomandibular (TMJ) joint appliances, foot orthotics, orthopedic and corrective shoes not attached to a covered brace, support, heel pads, heel cups, lumbo-sacral supports and devices otherwise excluded under the Plan. Replacements due to loss, theft, abuse, and neglect, or other than normal wear or change in functionality, are not covered.

Baby Formula: Is not covered, including prescription formulas unless the formula is approved on account of a genetic condition.

Behavioral Disorder: Includes both mental (psychiatric) treatment and disorders as well as addictive or substance abuse disorders. Medical disorders include charges for bulimia, anorexia, schizophrenia, paranoid disorders, affective disorders (depression, mania and manic-depressive illness/bipolar), anxiety disorders, somatoform disorders, personality disorders, psychosexual disorders, and any other organic disorder(s). Any treatment rendered by a mental/nervous or psychiatric facility will be considered a mental expense for purposes of the Plan and will be paid in accordance with the specific Mental Schedule of Benefits, whereas all addictive and/or substance abuse treatment will be paid per the Addictive Schedule of Benefits.

Biofeedback: Charges for biofeedback for the treatment of a specific disease or injury will only be covered if it is recognized as appropriate and will be paid as Any Other Benefit when performed by a duly licensed provider. Biofeedback provided via talk therapy will be paid as out-patient counseling benefit.

Case Management: Case management may be instituted by the Plan for those situations when a catastrophic illness or injury is likely to or already has occurred, resulting in charges that could exceed a dollar limit as established by the Plan (generally $25,000 or higher). In a case management situation, the Plan may extend or provide benefits that are normally not provided by the Plan. Generally, these benefits will be subject to the normal Plan copays and deductibles. Case management relies upon the patient and providers to communicate with them as to the current status, treatment, results, etc. Any extended treatment or special consideration of treatment will not be given by the Plan if there is insufficient information and/or cooperation from the member/patient or provider.

Child: Includes children, stepchildren, legally adopted children, children placed with the employee for adoption, and eligible foster children.

Claims Appeal of an Adverse Claim or Benefit Payment: See Part B of the Plan and the section on your claims appeal rights and procedures.

Claims Supervisor: An organization that administers the Plan's claims on a contract basis. See Essential Claims and Contact Information.

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 after those provisions become effective for this Plan.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance: This is a percentage of eligible or allowable charges that is considered the responsibility of the member or the plan. Most out-of-network services are subject to the NPPO deductible and coinsurance of 30%. This means the member is responsible for 30% of eligible charges after the deductible or copay (if applicable) until the member meets their Out-of-Pocket Limit on Coinsurance (separate limits apply to in

network providers and out-of-network providers.) See also the standardized Glossary of Terms in Part C and the coinsurance limits under the Schedule of Benefits.

Copay: This is a fixed dollar amount paid at point of service—generally for in network services only.

Contract Provider: This term applies to a provider who does not accept Medicare assignment and will not bill Medicare. The physician is required to notify you and he/she may ask you to sign a private contract agreeing to pay whatever he/she bills for services that would ordinarily be covered by the original Medicare Plan. If you sign such an agreement, Medicare will not pay any portion of the charge and the Plan will not increase the Plan's payment. This Plan limits payment to the amount that would have been paid after Medicare payment, e.g., usually 35% of Medicare Allowed Charges.

Court Ordered Treatment: Includes any treatment mandated, recommended, or agreed to in order to mitigate any fine or punishment in conjunction with any act the court has jurisdiction over. Court ordered treatment is not covered. Voluntary or preemptive treatment taken in order to avoid civil or criminal penalties is considered the same as court ordered treatment and such treatment will not be covered.

Covered Person: The primary member is an employee or retiree of a participating employer who is controlled by or related to the Plan Sponsor and who meets the following requirements:

- Meet the requirements of being an eligible employee or retiree;
- Who completes an enrollment form timely and elect coverage including coverage for a legal spouse or dependent of an eligible employee as permitted by the Plan; and
- Makes any required contribution, including contributions for eligible dependents, for elected coverage.

Coverage may be denied retroactively to the date that a member, spouse or dependent becomes ineligible for coverage (e.g., no longer a legal dependent) or for failure to pay the member portion of the cost of coverage, including COBRA coverage. Coverage may be reinstated retroactively due to administrative error. Otherwise, coverage will be effective, as provided by the Plan, following the date the requirements are met.

Covered Medical Expense: Limited to "allowable charges" incurred for covered medical services, supplies and treatment. Services must be medically necessary, except for preventive and wellness benefits specifically provided for in the Plan. All services must be provided by or under the supervision of a physician or medical practitioner, as defined by the Plan, acting within the scope of his/her license in order to be covered.

Custodial Care: Assistance provided with routine activities of daily living (e.g., bathing, dressing, eating, running errands, etc.). Generally, such assistance is considered custodial care if an untrained adult can provide it with little or no instruction or supervision. Hospice Care provided for a terminally ill patient will be covered as provided in the Schedule of Benefits. Nursing home care is not covered.

Deductible: The specified amount of eligible charges the insured member must pay first before payment of Plan benefits can begin, except for those specific benefits in the Schedule of Benefits where the deductible is waived.

Dental Care: Limited to oral or maxi facial surgery due to treatment of features of the jaw or facial bones, removal of stones from salivary duck, excision of benign or malignant lesions, tremors or cysts, and surgical treatment of TMJ which must be pre-authorized. Dental implants and dental care such as restoration for TMJ are not covered. Only those members enrolled in the dental plan are eligible for dental benefits under this Plan.

Dependent: Spouse, "qualifying child" or "qualifying relative" who qualifies as a dependent for federal income tax purposes and IRS rules.

Disabled: An employee must be unable to perform the normal duties of his/her occupation, or employment, or a covered dependent must be unable to perform the normal activities of a person of like age or sex as determined by an independent physician. As defined by the Plan or policy, disability for the purposes of

life insurance or disability insurance. Disability for purposes of continuing coverage of a disabled dependent after age 26 shall be as defined by state law or the Social Security Administration. A doctor's certification of permanent and total disability whereby a dependent is incapable of self-support is required prior to the dependent's 26th birthday and must be prior to the maximum age for coverage as a child by age under this Plan.

Durable Medical Equipment (DME): Medical supplies of a non-disposable nature that can withstand repeated use, used primarily for a medical purpose, are generally not useful to a healthy person, and are appropriate for use in a patient's house. Benefits are provided for the rental or purchase, if appropriate, when ordered by an attending Physician and found medically necessary. Equipment must be custom for in-home use and include standard hospital beds, respirators, canes, crutches, walkers, and wheelchairs. **Any DME purchased by the Plan must be returned to the Plan when it is no longer needed; otherwise, the cost of the DME is considered taxable income to the member according to IRS rules.** DME replacements can be covered only if medically necessary due to a change in body condition or are no longer repairable due to normal wear and tear. Replacements due to abnormal use, misuse, theft, or other loss will not be covered.

1. **Covered DME Items**: Home oxygen equipment, respirators, standard hospital beds, canes, walkers, crutches, wheelchairs, power wheelchairs, prosthetic devices, prosthetics, therapeutic shoes, home dialysis equipment, and orthotics.
2. **Medicare Primary Members:** Must purchase Medicare eligible DME only from approved Medicare Providers. Please refer to Medicare Publications 11437 and 11045. Medicare eligible DME includes the following: Home oxygen equipment, Hospital beds, Walkers, Wheelchairs, Power Wheelchairs, prosthetic devices, prosthetics, therapeutic shoes, home dialysis equipment, and orthotics. If a Medicare Primary member fails to use an approved Medicare provider, the benefit under this plan will be the same as if the service was provided by a Contract Provider.
3. **DME Exclusions:** DME does not include hearing aids, batteries, eyeglasses, contact lenses, blood pressure monitors, thermometers, shoes or other articles of clothing, communication devices, computers, air conditioners, purifiers, humidifiers, exercise equipment, pools, spas, physical fitness equipment, bathroom equipment such as bathroom scales, benches, rails or lifts, and comfort items or convenience items. **Exception**: If a DME item not specifically covered by the Plan "may" be covered as any other benefit payable at 70% if it is deemed to be both medically necessary and cost efficient for the Plan to be provided in the home (such as exercise equipment) in lieu of other medically necessary therapy or services. No retrospective approval of DME will be granted under this exception. Such exception must be applied for and pre-certified or approved in advance. The maximum benefit paid for DME as an exception is limited to $10,000.

   Deluxe equipment, such as motor-driven chairs or beds, when standard equipment is adequate, will not be covered unless medically necessary and circumstances dictate otherwise, at the sole judgment of the Plan. Home modifications such as stair glides, elevators and wheelchair ramps, wheelchair lifts, and accessories to adapt to outside environment or convenience for work or to perform recreational activities are not covered. This list is not all-inclusive and could include other items of equipment the Plan determines does not meet the general criteria for coverage.

Effective Date of Coverage: The date benefits under the Plan are available to the employee. An employee's effective date of coverage is the date specified in the General Limitations Section providing he/she enrolls for coverage in a timely manner as required by the Plan. No retroactive enrollment or coverage is permitted, absent special circumstances except for newborns or adopted or foster children placed in the home or when a Qualified Medical Child Support Order (QMCSO) is in effect.

Eligible Dependents: Includes spouses and children per the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (PPACA), also known as Health Care Reform or HCR as may be amended from time to time. After age 26, any child must meet the dependency rules under IRC §152 and not be eligible for coverage under Medicare.

Eligible Expense: This is the portion of the charges that are considered by the Plan for benefit payment. See Allowable Charges/Eligible Charges in Part B.

Emergency or Life-Threatening Condition: 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.

Enrollee: An employee or retiree who has specific enrollment rights under the Plan as a result of his/her employment relationship with the Plan Sponsor and per the eligibility rules in Part A. Qualified beneficiaries who have special enrollment rights under COBRA rules, as a result of losing coverage, are not considered enrollees.

Enrollment Date: The term "enrollment date" has a specific meaning under HIPAA and is the date of enrollment in the Plan, generally meaning the first day of coverage. However, if there is a waiting period before you are eligible for benefits, the enrollment date is the beginning of the waiting period, which is generally the date of hire. Enrollment date for purposes of becoming eligible to receive benefits under the Plan is the date your enrollment application is completed and turned into the Trust/Plan, if you enroll during your initial enrollment period, for purposes of any special enrollment or change in family status.

Exclusions: Benefits or services that are specifically excluded and benefits limited in terms of visits or dollar amounts. Certain benefits may also be limited or excluded by reason of the definition in the Plan document or on account of third-party liability. Injuries on account of third-party liability are not covered except as a subrogation claim or lien against any settlement received directly or indirectly by the covered member from the responsible party or their insurer. Subrogation claims also include recovery from any uninsured or underinsured motorist's coverage.

Experimental, Investigative Services or Supplies: 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."

Extended Benefits: Extended benefits may be provided, subject to medical necessity requirements of the Plan, and/or as an alternative to hospitalization that is shown to be effective medically and/or from a cost standpoint (e.g., home nursing or skilled nursing care may be a viable and cost-effective alternative to hospitalization). Extended benefits are granted at the sole discretion of the Plan, based on the facts and circumstances of each situation. The Plan reserves the right to institute disease management for chronic illnesses or injuries. Extended benefits for physical or other therapies, including chiropractic treatment, may be subject to higher copays or coinsurance as provided by the Plan, if extended treatment is approved.

Approval of extended benefits will be at the sole discretion of the Plan and are subject to advance approval by the Pre-certification or Compliance Office based on all facts and circumstances. Granting an extension of benefits does not provide or guarantee any right to future or additional extensions of benefits. The extension of benefits is for unique and unusual circumstances and does not constitute a right to extended benefits. Benefits will not be extended for custodial, maintenance care, or home nursing care after maximum medical improvement has been made.

Foot/Podiatry Care: Foot care shall be covered the same as any other medical benefit. Foot orthotics or orthotic shoes are limited to one during any 12-month period, subject to the podiatry benefits in the Schedule of Benefits. Compression Stockings coverage is aligned with Medicare guidelines for treatment and diagnosis of open venous stasis ulcers. Compression Stockings are limited to six (6) pairs per year.

Foreign Coverage: Retirees living permanently outside the U.S. will be covered per the NPPO Schedule of Benefits, if proof of residency is provided and non-residence status is approved by the Plan, at its sole

discretion, depending upon the country in which the retiree resides. Coverage in countries that are considered "high risk areas" may not be approved, at the sole discretion of the Plan. Students on exchange-type programs or studying abroad will not be covered, unless pre-approved by the Plan, except for emergency care.

Fraud, Waste and Abuse: See Part C for a complete summary of the Plan's Fraud, Waste and Abuse provisions.

Genetic Testing: Genetic testing is generally not covered unless there is a family predisposition history for certain genetic illnesses and/or due to ethnic background. For genetic testing to be covered, a determination must first be made by the Plan that testing is medically necessary for the treatment of an existing illness or condition, such as pregnancy, or to make an advance determination in an unborn fetus for a genetic condition. Genetic testing for preventive purposes is not covered. Upon submission to the Pre-certification Department by your physician of the reason for a test, the Plan will make a determination whether the test will be covered, provided the information is submitted prior to having the tests performed. The members will be responsible for paying for any tests that are not pre-approved. Genetic testing, if pre-approved, will be paid as Any Other Benefit.

Grandfathered Plan: For purposes of the Health Care Reform enacted March 23, 2010, the KTF medical plan is not a grandfathered plan. This plan was restated in its entirety solely to incorporate numerous changes required both by this act and the Mental Health Parity and Addictive Equity Act Interim Final rules effective July 1, 2010. This Plan is governed by the PUBLIC HEALTH SERVICE ACT (PHSA) and is exempt from all state rules and requirements governing insurance.

The dental plan, which is considered as a separate plan available individually or in addition to the group health plan, is a grandfathered plan and only those PPACA changes as adopted by the Plan shall be incorporated for purposes of the dental plan, for example the coverage of children 19 to 26 applies to both the medical and dental plan. The elimination of annual maximum limits does not apply to the dental plan as a grandfathered plan.

Health Care Reform (HCR): Common reference to describe benefits or rules in accordance with the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (PPACA), also known as the Affordable Care Act (ACA). To the extent subsequent amendments to this Act or possible rescissions of certain provisions are passed, those changes shall be deemed to automatically be incorporated for the purposes of this Plan. As provisions become applicable, they shall be deemed to be incorporated in this Plan until a formal amendment or restatement of this Plan is made. Any optional changes will only be considered when formally adopted by the Plan Administrator or governing body.

Home Healthcare Agency: An agency or organization that provides in-home healthcare and meets the following criteria:

1. Approved as a Home Health Agency under Medicare, or is established and operated in accordance with the applicable laws in the jurisdiction where it is located and, where licensing is required, has been licensed and approved by the Regulatory Authority having responsibility for licensing under the law;
2. An agency that holds itself forth to the public as having the primary purpose of providing an in-home healthcare delivery system and supportive services;
3. Has a full-time administrator and maintains written records of services provided to the patient;
4. Its staff includes at least one registered graduate nurse (RN) or has an RN available for services;
5. Its employees are bonded, and it provides malpractice insurance; and
6. Treatment programs are established and approved in writing and certification is provided by an attending physician that the proper treatment of the disability would require continued confinement, as an inpatient in a hospital, in the absence of services and supplies provided as part of an in-home healthcare treatment Plan. Each visit by a representative of a home healthcare agency will be

deemed to be one home healthcare visit. However, in the case of in-home health aide services, four (4) hours will be deemed to be one home healthcare visit.

Home Health Services: These services must be ordered by a Plan physician and provided by Home Health Aides and Nurses. Services must be periodically reviewed by the Plan physician for appropriateness. Home nursing needs requested by the patient or patient's family, for the convenience of the patient's home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative, are not covered. Services provided by a family member or resident in the member's home are not covered, nor are services rendered at any site other than the member's home.

Hospital: An institution that is engaged primarily in providing medical care and the treatment of sick or injured persons on an inpatient basis at the patient's expense and fully meets all the following tests:

1. It is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.
2. Maintains, on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis, and treatment of sick and injured persons by or under the supervision of a staff of fully qualified physicians.
3. Continuously provide a 24-hour nursing service on the premises by or under the supervision of registered graduate nurses.
4. Is operated continuously with organized facilities for operative surgery on the premises.
5. A "hospital," "psychiatric hospital," or "tuberculosis hospital," as these terms are defined by Medicare, and are qualified to participate and eligible to receive payments in accordance with Medicare provisions.
6. The term "hospital" also includes any institution duly licensed by the state in the jurisdiction where the hospital is located, as a "psychiatric" or other specialty hospital.
7. The term "hospital" excludes the following:
    a. A convalescent home (except as provided above);
    b. Place for custodial care;
    c. Nursing home except when pre-approved as a skilled nursing facility or for hospice care;
    d. Rest home or assisted living facility;
    e. An institution for the treatment of the aged;
    f. An institution for the drug or alcohol addicted, even though such institutions may be licensed by the state in which it is located;
    g. A hospital contracted for or operated by the Federal Government, if the patient is not legally obligated to pay the expenses for the hospitalization; and
    h. All hospitals and medical facilities are considered independent contractors, and this Plan will not be liable in any lawsuit or claim for injuries received as a result of any services or diagnosis provided by any provider. Nothing in the Plan will be deemed to create a relationship of employer and employee or of principal and agent between this Plan and any provider.

Institutional Charges: Eligible expenses incurred in and billed by a hospital or ambulatory surgical center, as defined above shall be covered as provided by the Plan. Other institutional charges for a nursing home, assisted living facility, long term care facility (including long term institutional care for a mental health or addictive condition that cannot be favorably changed by treatment), personal care facility, educational facility for special needs children, or halfway house shall not be covered unless approved under case management.

Investigational and/or Experimental Treatment: The following are excluded charges unless the treatment has been pre-approved by the Plan (see Clinical Trials):

1. Treatment not accepted as standard medical treatment for the illness, disease, or injury being treated by physicians practicing in the suitable medical specialty;
2. The subjects of scientific or medical research or study to determine the item's effectiveness and safety;
3. Treatments that have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including, without limitation, the Federal Department of Health and Human Services, Food and Drug Administration, any comparable state governmental agency and the Federal Healthcare Finance Administration, as approved for reimbursement under Medicare Title XVIII; or
4. Treatment that is performed, subject to the covered person's informed consent, under a treatment protocol that explains the treatment or procedures conducted as a human subject study or experiment.

Medical Condition/Substance Abuse: Includes conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD; or disorders listed in the ICD requiring treatment for abuse of, or dependence upon, substances such as alcohol, narcotics, or hallucinogens.

Never Events: Errors in medical care that are clearly identifiable, preventable, and serious in their consequences, such as surgery performed on a wrong body part, and specific conditions that are acquired during your hospital stay, such as severe bed sores.

Medically Necessary/Medical Necessity: The fact that one of our covered physicians, hospitals, or other professional or facility provider(s) prescribed, recommend, or approve a service or supply does not, in itself, make it medically necessary or covered under this Plan. 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)*, per 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 in a timely manner, per the provider's policy. Also, see Medical Necessity Notice in Part C.

Member: An employee or retiree who has enrollment rights under the Plan. They may also be referred to as the Primary Member or Insured. Dependents are covered dependents, not a "member" per se, but in general context may be referred to as members.

MHPAEA: Refers to the Mental Health and Addiction Equity Act of 2008 and the rules and regulations thereunder. The Interim Final Rule was issued February 3, 2010, and is effective July 1, 2010.

Observation Services: Hospital outpatient services ordered by the physician to assess whether the member needs to be admitted as an inpatient or can be discharged. If you are in the hospital more than a few hours, always ask your physician or the hospital staff if your stay is considered inpatient or outpatient. Although you may stay overnight in a hospital room and receive meals and other hospital services, some hospital services – including "**observation services**" – are considered outpatient care. Since observation services are billed as outpatient care, outpatient facility benefit levels apply, and your out-of-pocket expenses may be higher.

Optometrist: Any Doctor of Optometry (D.O.) who is legally authorized to practice optometry in any state. An optometrist will be considered a "doctor", as state law defines the term. No services performed by an optometrist will be covered under the Plan unless the same services would have been covered if a medical

doctor had performed them. If there are questions about optometric coverage, employees can call the Claims Supervisor for clarification.

Orthotics/Prosthetics/Braces: See artificial aids and foot care/podiatry.

Out-of-Area (OOA): Enrollment as an OOA member is limited to retirees living permanently outside the primary coverage area (more than 75 miles). Full-time students attending school outside the primary coverage area may also be enrolled for OOA benefits. OOA status will not be available after notice from the Plan that there is an extensive availability of PPO providers in a specific coverage area. Prior to an area being exempted from OOA status, due to coverage by the PPO providers, advanced notice will be given to all members residing in that area to permit them time to make appropriate changes in providers, if they wish. OOA status is not available for retirees or students living outside the U.S. (See Foreign Coverage).

Exceptions will be made only if written consent and approval is received from the Compliance Office. Out-of-Area (OOA) status is at the sole discretion of the Plan and subject to approval, based on individual facts and circumstances of the member. All appeals must be filed in writing with the Compliance Office. OOA status is not available to active employees or their dependents, they are deemed to live within the Plan area by reason of their employment, except for full-time students who are attending school out-of-the-area. OOA status will become effective as of the request for such status and cannot be made effective retroactively.

Out-of-Pocket: This is the maximum amount of member cost sharing—usually a separate limit applies for in network versus out-of-network services. Out-of-pocket includes the employee portion of the cost sharing, including copays, coinsurance and it may or may not include the deductible, as set out in the Schedule of Benefits.

PPACA: means the Patient Affordability and Accountability Act of 2010, as amended. It is also referred to as the Affordable Care Act (ACA) or as Health Care Reform.

Partial Hospitalization: An intensive facility-based treatment program during which an interdisciplinary team provides care related to mental health and/or substance abuse conditions. Program sessions may occur more than one day per week and may be full or half days, evenings, and/or weekends. The duration of care per session is less than 24 hours. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Participating Employer: An employer either controlled by, under common control with, or otherwise related to the Plan Sponsor and who is eligible and has elected to participate in the Plan.

Physical and Occupational Therapies: These are covered only to restore bodily function when there has been a total or partial loss of function due to disease or injury. Occupational therapy is limited to services to assist the member to achieve and maintain self-care and improve function in daily living activities.

Physician Assistant: A person who is nationally certified by the National Commission on Certification of Physician Assistants in conjunction with the National Board of Medical Examiners or, if the state requires it, is licensed, certified, or registered as a physician assistant where the services are performed.

Physicians and Other Medical Providers: The following practitioners who are licensed to practice in the state where services are performed and operate within the scope of their license are considered approved providers unless they are otherwise excluded due to family relationship. Any provider is considered an independent contractor, and the Plan will not be liable in any lawsuit or claim for injuries received as a result of any services or diagnosis provided by any provider regardless of whether the provider is a network provider or an out-of-network provider. Services of medical providers, other than those listed, will not be covered, unless approved by the Plan Administrator in advance of any treatment, based on medical necessity and the cost effectiveness under a Case Management program. For reference, following is a list of excluded and approved medical providers:

- **Excluded Providers**: Physicians or other medical practitioners, even if listed above, may not be a member of the patient's immediate family (include brother, sister, stepbrother or sister, aunt, uncle, parent or stepparent, niece, or nephew, related by blood, marriage, or adoption) or any member of the patient’s household. No benefits will be provided for services provided by an excluded provider.

- **Approved Providers:**

1. Any Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who is licensed by the Composite Board of the state where services are rendered (or similar board of another state).
2. Any licensed Doctor of Dental Surgery (DDS) who is legally entitled to perform oral surgery.
3. Any licensed Doctor of Podiatry Medicine (DPM) who is legally entitled to practice podiatry medicine.
4. A licensed Chiropractor, Optometrist, Ophthalmologist, Podiatrist or Psychologist is recognized as a physician to the extent that he/she is performing services within the scope of his/her license in that state.
5. Other medical providers (subject to licensing required by the state in which the services are performed) include:

a. A licensed practical nurse (LPN) who provides in-hospital, private-duty care;

b. Alternative providers (acupuncture, Christian Science Practitioners, holistic medical providers) who operate within the scope of their license by the state in which they practice;

c. Licensed massage therapist (LMT) under the supervision and working in the same office as a duly licensed chiropractor, DO, physical therapist or acupuncture practitioner;

d. A licensed physician's assistant;

e. Physiotherapist, when ordered by a physician;

f. A licensed social worker (LCSW or MSW);

g. Nurse;

h. Midwife; and

i. Registered nurse (RN).

Plan: "The Plan" constitutes the entire document and includes eligibility for benefits, various schedules of benefits and provisions for payment of benefits as set forth in this document. The Compliance Office, or the Plan, as appropriate, may establish operational procedures and policies to provide clarification and guidance and such policies shall be incorporated by reference.

Plan Administrator: The Plan Sponsor may include a Union or Collective Bargaining Group. The Plan Administrator has the exclusive responsibility and complete discretion to control the operation and administration of this Plan, including the relegation of various responsibilities (pre-certification, claims payment and compliance) over which the Plan Sponsor has ultimate control.

Prescription Drugs: Must be filled by a licensed pharmacist and qualify as one of the following: A Federal Legend Drug (limited to any medicinal substance, required labeling under the Federal Food, Drug and Cosmetic Act to bear the legend, *"Caution: Federal Law prohibits dispensing without prescription"*), as well as drugs that are specifically excluded and/or limited under the Prescription Provisions of the Plan:

1. Drugs that require a prescription under state but not federal law.
2. Compound drugs that contain at least one ingredient that constitutes a Federal Legend Drug or drug requiring a prescription under state law.
3. Injectable insulin that includes needles and diabetic testing supplies. Other injectables will not be covered under the prescription benefit program. Certain drugs, subject to pre-certification, may be covered as a major-medical expense as "Any Other Benefit" per the Schedule of Benefits.
4. Injectable drugs for serious or chronic illness, such as AIDS or HIV. The approval of such drugs will be based on the decision of the case manager, taking into account all facts and circumstances of the individual situation, including the cost factors of the different options.

5. Cosmetic drugs are not covered.
6. Vitamins are not covered, except for prenatal vitamins or mega vitamins due to a serious medical condition such as diabetes.
7. Specific drugs are further limited or provided as specifically stated in the Rx Schedule of Benefits and/or in the Plan (such as: diabetic and infertility drugs).

PHI (Protected Health Information): Under HIPAA, a detailed explanation of your HIPAA rights is included in the Privacy and Patient's Rights Policy section of the Plan.

Public Health Service Act (PHSA): This is the Act that governs non-federal governmental plans in lieu of ERISA. The code section which covers group health plans for non-federal government agencies and is a counterpart of and in lieu of ERISA.

Qualified Beneficiary: A covered person under the Plan on the day preceding the date of a COBRA event. Qualified beneficiaries have individual enrollment rights under COBRA rules to continue coverage for up to 36 months. (Please refer to the COBRA section for additional information on COBRA rights.)

Qualified Medical Child Support Order (QMCSO): A court ruling ordering medical or dental coverage to be provided by the designated parent or legal guardian. Plans are required to honor such orders and deduct the necessary portion of the cost from the employee's pay. Such coverage must remain in effect until the child reaches the maximum age for coverage per the order or when the order is removed by the court.

Room Accommodations: Room, board, general nursing services, intensive nursing services and any other services regularly furnished by the hospital, as a condition of occupancy of the class of accommodations occupied. This term does not include the professional services of physicians or special nursing services rendered outside of an intensive care or special-care unit. Generally, benefits are limited to semi-private rooms. Private rooms are not covered unless medically necessary or if that is the only bed available.

Self-Funded Plan: This Plan is a self-funded plan that is considered exempt from state insurance laws and is administered under the terms of this Plan and a Voluntary Employee Benefit Trust (VEBA) established under §501(c)(9) of the Internal Revenue Code (IRC). Payment of all benefits shall be made from Plan/Trust assets and as provided by any stop loss reinsurance coverage. The Board of Trustees is ultimately responsible for the overall administration and operation of the Plan, including the delegation of specific duties.

Stop Loss Insurance: Reinsurance that protects the Plan's assets in the event of a catastrophic individual claim or unusually high claims for the group as a whole. Providers or Members do not have any right of recourse or claims against the stop loss carrier.

Termination of Coverage: The end of health benefits provided by the Plan. Coverage of any covered person under the Plan will terminate at the end of the month during which a COBRA event occurs or the individual ceases to be eligible for coverage under Plan rules.

TPO Activities: Specific functions and activities that involve the permissible use of Protected Health Information on a need-to-know basis. TPO activities are defined by HIPAA as those concerning a member's treatment, payment, and operations (Healthcare Operations) of the Plan, including information required to secure coverage, etc.

30-Days: Any reference to 30-days shall mean one month and shall also mean 31-days when applicable but shall never mean less than 30 calendar days. Conversely, 60-days may also mean two months which may encompass 59 to 62 actual calendar days but will never be less than 60 calendar days.

Usual, Customary and Reasonable Fee (UCR): See Allowable Charges.

EXCLUSIONS – NON-COVERED BENEFITS

The Health Plan will not pay for any of the following benefits unless such benefits are specifically covered in the Schedule of Benefits for the Plan or are pre-approved as part of a Case Management or Pre-certification program. Certain charges may be excluded or limited based upon the specific definition of

certain terms used by the Plan and as specifically defined. For example, see the definition for physician/medical provider and medical necessity.

This list is not an exhaustive list. Certain services may not be covered based on Plan policy and practices, as may be established from time-to-time, that are in keeping with the general benefit structure and intent of the Plan. The Compliance Office will resolve all Plan interpretations, and the Plan will be administered based upon established written operating procedures and policies, as may be necessary to provide guidance and interpretation. Any exclusion in this section is superseded by specific benefits provided in the Schedule of Benefits.

Abortion: Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

Ambulance Service: The Plan will not pay for ambulance services used in a non-emergency situation or to routinely transport a covered person from a hospital, or other healthcare facility, unless the covered person is being transferred to another inpatient healthcare facility for testing, treatment, or confinement. Regular transportation for medical treatment is not covered except as provided under the transportation benefit under the Plan. If transport is needed for a patient who is not ambulatory and who requires assistance, arrangements must be made through the Utilization Review and Pre-certification Department.

Air ambulance benefits are limited to emergency care in life-threatening situations when regular ambulance service is not available or appropriate, due to the life-threatening or serious nature of an illness or injury. Delivery must be to the nearest appropriate facility.

Blood: The cost for the storage of blood, plasma, or other tissue is not covered, except in a situation when it might be required prior to surgery for "expected" use during a scheduled surgery for an existing condition. A procedure that requires advance storage of blood or plasma for a member must be pre-certified and pre-approved in advance of the procedure.

Custodial/Non-Medical Care/Long-Term/Institutional Care: Charges you are otherwise not legally responsible for, such as: from a rest home, place for the aged, nursing home, extended care facility, custodial care, charges for education, training, bed, and board in an institution, which is primarily a school or a place for training, will not be covered. Custodial care is defined as care that consists of services and supplies (including room and board) furnished to an individual primarily to assist him/her in the activities of daily living; and the care is not reasonably expected to substantially improve the individual's medical condition. Nursing home or institutional care that is primarily custodial, educational, or long-term care, once the individual has reached maximum medical or psychological improvement, including long term care for acute mental disease or illness, including autism, addiction, bipolar disorder, schizophrenia, dementia, Alzheimer's etc., even if confinement is medically necessary because the patient is unable to be cared for at home or is a danger or risk to themselves or others. Group homes and halfway houses are not covered.

Dental Care (Limited Benefits): Separate dental coverage will always be considered primary to this coverage. All other dental-related services are not covered under the medical plan, including injuries due to biting and chewing, except for medically necessary procedures due to a genetic or other medical condition which will be covered as any other benefit, after the deductible.

The medical plan does not cover any care directly related to the care, filling, removal, replacement of teeth, the treatment of injuries, disease of the teeth, or any other medical condition, gums or structures directly supporting or attached to the teeth. Charges for orthodontia, dentures, removal of teeth, examinations, fittings, and dentures or dental implants are not covered under the major-medical Plan, except for the surgical removal of an impacted tooth or for reconstructive surgery necessary to repair natural tissues damaged by an accident. Charges for treatment or repair of Temporomandibular Joint Dysfunction (TMJ) will not be covered in excess of the amount listed, if any, in the Schedule of Medical Benefits, except for orthotics splints or surgery when pre-approved under the Plan. If you have any doubt about whether surgery in the jaw area will be covered, check with the Claims Supervisor.

In the case of an accident or injury, dental benefits will be paid as any other benefit. Dental implants to replace broken teeth that have been removed, due to a medical condition or accident, are not covered under

the Plan. Any benefit paid in conjunction with an accident that involves dental work must be pre-approved by the Plan in advance of treatment. No benefits will be approved or pre-certified retrospectively.

Drug and Alcohol Addiction: See definitions. Limits to benefits provided in the Schedule.

Educational Expenses: Charges in conjunction with any educational facility or treatment program are not covered, except for any ancillary medical charges that may be made in conjunction with counseling for a behavioral condition (mental or addictive). Tuition or room and board fees are not covered in conjunction with a halfway house, group home or special educational facility.

Excess Charges: Charges that exceed allowed charges are otherwise not allowed. Members are responsible for paying all excess charges, in addition to their deductible, copay, or coinsurance percentage under the Plan. Excess charges are never credited towards your out-of-pocket limit.

Experimental Treatment: Charges for any procedure or service that is judged by the Plan Administrator or Claims Supervisor, at their sole discretion, to be experimental in nature, are not covered, unless the treatment is subsequently approved in writing. Certain programs may be considered.

Food Supplements: Food supplements are not covered by the Plan, including baby formulas (prescription and non-prescription). Diet programs such as Nutri-System or Jenny Craig for weight loss are not covered by the Plan. Enteral formulas are subject to prior plan approval and pre-certification for medically necessary (a disease-specific method of treatment for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic physical disability, mental retardation, or death, if left untreated) benefits will be provided up to a maximum of $2,500 a year. This includes modified solid food products for treatment of certain inherited diseases of amino acid or organic acid metabolism. All such treatment is subject to pre-certification and a written prescription from a provider that specializes in the treatment of such disorders. The maximum benefit for modified solid food products is limited to $2,500 per year and benefits are payable as Any Other Benefit, subject to the Plan deductible. The member's coinsurance for supplements will not be credited toward the out-of-pocket limit.

Foreign Travel/Transportation Cost Back to The U.S.: Generally, all treatment outside the United States or U.S. territories is not covered under this plan except for emergencies. Transportation back to the United States due to a medical condition is not covered unless it is due to an acute condition and medically necessary to return the patient to the U.S. as soon as possible. Students studying abroad are not covered except for emergency care. Individual health coverage should be purchased for anyone who plans to reside outside the country for more than six weeks. See Immunizations/Vaccines.

Genetic Counseling and/or Screenings: Charges for genetic counseling or DNA testing are not covered. Genetic screenings are not covered unless pre-approved by the Plan based on medical necessity due to family history for preventive or treatment purposes. Diagnostic genetic tests are only covered if pre-certified and approved in advance of treatment. Retrospective pre-certification is not permitted for such tests.

Growth Hormone Therapy (GHT): This is not covered unless it is pre-approved prior to treatment and is determined to be medically necessary.

Hospital Confinement: Charges primarily for physiotherapy, hydrotherapy, convalescent, rest care, or other routine physical examination not connected with an illness or injury are not covered.

Illegal Acts: The Plan will not pay for care and treatment of conditions caused, directly or indirectly, by (a) a covered person taking part in a civil disorder or riot; or (b) a covered person taking part in a felony, illegal activity or attempting to commit a criminal act.

Immunizations/Vaccines: Non-routine immunizations or vaccines are not covered, including special vaccinations in conjunction with travel abroad or to a foreign country. Also, see Preventive Vaccines and Immunizations.

Infertility: Infertility is defined as the inability to conceive after 12 months of unprotected intravaginal sexual relations (or 12 cycles of artificial insemination).

Methadone and Methadone Maintenance Drugs: are not covered.

Miscellaneous Charges: Charges for the completion of a claim or medical information form, as well as other non-medical items, are not covered. Penalties for failure to show up for a scheduled office visit are not covered. The Plan will not pay for services and supplies that are specifically limited or excluded in other parts of the Plan, or which are not prescribed by or performed by a physician. The Plan will not pay for medical supplies such as vitamins (except for prenatal vitamins), food supplements (including non-prescription food supplements for Phenylketonuria (PKU) and other metabolic illness), and other non-medical expenses not covered under the terms of the Plan.

Non-Covered Expenses: A "non-covered expense" is an expense that the Plan will not consider for payment. It is impossible to list every specific item that would be excluded under the general intent of the Plan and within the context of the benefit provided. New FDA-approved treatment and procedures will generally be covered within the benefits provided, except for preventive-type medications. In these instances, the Plan's decision will be based on medical necessity and long-range, cost-benefit analysis.

When appropriate, interpretive memoranda will be put into effect to clarify or provide appropriate Plan interpretation and procedures for paying certain benefits, and the memoranda or directives will be incorporated herein by reference. The following list identifies specific items that are never covered, unless otherwise specifically provided for in the Schedule of Benefits:

1. Adoption fees;
2. Charges for experimental surgery;
3. Charges for rental of a television set in a hospital room;
4. Charges for services not medically necessary, such as cosmetic surgery. Any surgery of a cosmetic nature to correct congenital deformities due to an accident or injury is not considered cosmetic surgery. Coverage of cosmetic surgery is prohibited under IRS regulations;
5. Charges while confined to a government institution or hospital, including a Veterans' Administration hospital or facility, except charges for non-service-related injuries/illnesses that are subject to reimbursement under the Veterans Cost-Shifting Law or any other law, from the group health plan;
6. Charges incurred for the covered person they are not legally obligated to pay, or for a charge that would not ordinarily be made in absence of this coverage;
7. Charges for services provided outside the U.S. are limited to emergency care and as provided under Foreign Travel as foreign coverage for members permanently residing outside the U.S. or as approved by the Plan;
8. Maternity charges for a surrogate mother or an individual who is not a covered member under this Plan;
9. Room and board charges for any period of time when the covered person is not physically present;
10. Medical services/supplies, not provided by an authorized physician or medical practitioner, as defined by the Plan, operating within the scope of his/her license;
11. Charges for benefits that are excluded under the Plan, either by definition or by specific exclusion;
12. Any costs associated with the drawing/preserving of blood prior to surgery to be used if a transfusion is required during surgery. This expense is not medically necessary unless it is known in advance of the surgery that a transfusion will be required. If blood is drawn for this purpose, in advance, at the patient's expense, and becomes necessary to use this blood during surgery, the Plan will then reimburse the patient the cost of the actual transfusion at the normal cost per pint of blood;
13. Any costs associated with the withdrawal/preservation of sperm or eggs for purposes of future impregnation and/or fertility treatments are not covered unless as part of an approved infertility treatment program, subject to Case Management and prior approval. Any services rendered in anticipation of potential infertility in the future are not covered, as such services are not medically necessary at the time of the service;

14. Charges for treatment that is covered or provided by a school, state, or federal government for the treatment of certain conditions, such as speech therapy for underdeveloped children or children with speech impediments or other physical or mental impediments requiring specialized care;
15. Charges for Custodial, Nursing Home, Long Term, or specialized educational type care in an institution for individuals who are not capable of caring for themselves or who need specialized care, including education or training due to a physical or mental illness or defect;
16. Charges for DNA testing, stem cell research, storage of stem cells, or related charges;
17. Genetic testing, except as specifically provided and approved by the Plan;
18. Prescription charges made by any covered member, their spouse, or dependent when this Plan is not the primary plan, may only be covered under the special coordination of benefit provisions for prescriptions. If any covered member misuses the Rx card, they will be liable for reimbursing the Plan in full and filing directly with their primary insurer for reimbursement;
19. Neurofeedback and Neurotherapy, including software and equipment for home use are not covered;
20. Any other charges as determined by the Plan that are not specifically covered under the Schedule of Benefits; and
21. Charges for any drugs to replace those that were lost, stolen or misplaced are not covered. These are the member's responsibility unless they are reimbursable under other insurance such as auto or homeowners' insurance in the case of theft.

Non-Prescription/Over-the-Counter Drugs: Charges for drugs such as aspirin, acetaminophen, cough syrup, decongestant, etc., even if a doctor prescribes it, are not covered except for those items that are mandated under Health Care Reform Act as a preventive benefit.

Nuclear Accident: Expenses incurred due to a nuclear accident or terrorist act are not covered.

Nursing Home Care: Nursing home, long-term care, assisted living care, custodial care and/or related expenses are not covered by the Plan when the care is not in lieu of hospitalization or skilled nursing care, due to medical necessity.

Preventive Care/Wellness Charges: Charges that are not specifically related to the care and treatment of a sickness or an injury are not covered, except as provided in the Schedule of Benefits. Charges for any services or supplies that are not considered medically necessary by the Plan are not covered, except as provided in the Schedule of Medical Benefits or are mandated under the Health Care Reform Act of 2010.

> Example: Educational testing or training, physical examination given primarily for the protection, use, or convenience of third parties, including, but not limited to, employers and school insurers, are not covered, regardless of any preventive care benefit under the Plan.

Routine vaccinations and inoculations are considered medically necessary and are covered as any other benefit. Non-routine vaccinations are not covered.

> Example: Vaccinations required by a school, employer or for personal travel, such as meningitis or TB, will not be covered unless the vaccination is specifically covered in the Schedule of Benefits. Medically necessary vaccinations, due to direct exposure to a communicable illness such as hepatitis, will be covered.

Sex-Related Treatment: Charges for the following are not covered unless benefits are specifically provided in the Schedule of Benefits, or under the Infertility Program. Sex-related surgical procedures are considered "cosmetic" by the IRS are not eligible medical expenses under §213 of the Internal Revenue Code.

1. Sex-related treatment is not covered unless specifically provided for under the Schedule of Benefits;
2. Services related to sexual dysfunction, impotence, or inadequacies (see infertility/impotence);

3. Voluntary abortion (see Voluntary Abortion);
4. Reversal of voluntary surgically induced sterility; and
5. Intersex surgery (transsexual operations) or other care, services or treatments for non-congenital transsexualism, gender dysphoria, or sexual reassignment or change are not covered, in any event, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment (see Sex-Related Treatment).

Storage Costs: Cost to retrieve or store blood, plasma, eggs, sperm, body organs, stem cells or tissue are not covered.

Subrogation/Third-Party Claims Settlement: Subrogation permits the Plan to be reimbursed for services or supplies when payments are received because of claim settlement or legal action (third party claim or action), other than from an insurance carrier under an individual policy issued to you or your dependent. Benefits will be advanced by the Plan until the legal action is resolved only under the subrogation provisions of the Plan. Failure to comply with the Plan's subrogation provisions, in the event of an accident, injury, or illness when there is third-party liability, could result in denial of benefits or loss of benefits.

Therapy: The following types of therapy are not covered:

1. Charges for therapy in connection with meeting a patient's motivational needs and not related to a specific, diagnosed, or psychiatric illness;
2. Rehabilitative therapy, or restorative therapy, not for therapeutic purposes, or when no significant improvement is expected within a reasonable and generally predictable period of time;
3. Charges related solely to specific employment opportunities, work skills, work settings and exercise equipment or similar devices; and
4. Any therapy, in excess of therapy that was pre-approved by the Plan, or that exceeds the limits under the Plan, without prior approval or authorization under Case Management.

Transplants: Charges for acquisition, donation, and transportation of any covered organ, when a transplant is performed, will not be covered, except as provided in the Schedule of Benefits.

Transportation: Charges are not covered, except for a state-licensed ambulance service that is approved by the Plan, as medically necessary in the case of an emergency. Regular transportation for treatment, on a non-emergency basis, is not covered unless the patient is not ambulatory and needs assistance. Only specific ambulances or other transportation services that are pre-certified will be covered.

Treatment Outside the U.S., Canada, or Mexico: Treatment is not covered, except for emergency treatment, while traveling "temporarily" for a period not exceeding six (6) weeks in any one country or three (3) months in total. Any service provided outside the U.S., Canada or Mexico will be subject to the normal NPPO Plan deductible as copay for each incident. The deductible/copay will not be credited to your NPPO deductible or out-of-pocket limit under the Plan. After the deductible/copay is met, the member will be responsible for the basic NPPO coinsurance up to the NPPO Out-of-Pocket limit for emergency service or for any other non-emergency service, as pre-approved by the Plan.

Non-emergency treatment of chronic illness requiring hospitalization outside the United States will not be covered unless the treatment is pre-authorized within 24 hours of admission (72 hours if hospitalized over the weekend). No approved services for medical services rendered outside the U.S. are covered.

Emergency Treatment in Canada or Mexico will be subject to the same Emergency Room copay as treatment within the U.S.

Retirees living permanently outside the U.S. are generally covered, per the NPPO Schedule of Benefits, if proof of residency is provided and non-residence status is approved by the Plan, in advance. The approval will be at the sole discretion of the Plan, based on all relevant facts and circumstances, including the country in which the retiree resides. Coverage in countries considered "high risk" areas will not be approved, subject to the sole discretion of the Plan. Students on exchange-type programs are not covered. Parents are advised

to secure special travel and medical insurance through their travel or insurance agent, or their school for extended travel, or if they or a dependent intends to live abroad for an extended period.

Usual, Customary and Reasonable (UCR) Charges: See Allowable Charges Section.

Vision Charges: Charges for diagnosis, treatment, or for the correction of farsightedness, nearsightedness, or astigmatism, eyeglasses or contact lenses, examinations to determine the need for them or their fitting, vision care of any kind, unless for the diagnosis or treatment of eye disease, except for specific vision benefits specifically provided under the Schedule of Benefits. Vision implants or any other corrective procedures to improve vision are not covered, except as specifically provided in the schedule (i.e., Lasik Surgery).

> Example: Examination for glaucoma is not a covered medical expense unless the patient has been diagnosed with glaucoma. Cataract surgery would be covered as a medical expense, but any special lens implant would not be covered.

War/Service in Armed Forces: Expenses that result from loss or damage directly or indirectly, due to any act of war (whether war is declared or not), including resistance to armed aggression, will not be covered unless otherwise required by law.

Weight Reduction: Weight loss programs are not covered except for morbid obesity (130% of the Metropolitan Recommended Weight Table) under the care of a physician. Any special diet or food programs are not covered under the Plan.

Work-Related Injury/Illness: Charges for disability incurred for illness or injury that would entitle the covered person to benefits under a Worker's Compensation act or similar legislation. Any work-related injuries, due to occupation or employment for wage or profit, are not covered for any individual who is subject to Worker's Compensation coverage and is not exempt from Worker's Compensation laws. Only non-occupational injuries and diseases are covered under the Plan.

1. Self-Employed Spouses: Employees whose spouses or dependents are self-employed are cautioned to take steps to obtain Worker's Compensation coverage for occupational/job-related injuries or illnesses, even if they are not required to purchase coverage under state laws due to a minimum number of employees. Exempted for purposes of Worker's Compensation is defined by the state law where the claimant works and has a different meaning than "not required" or "optional."
2. Exceptions for the Self-Employed: A work-related injury or illness incurred by an employee who is exempted by state law from Worker's Compensation and who is not covered by Worker's Compensation will be covered.

ELIGIBILITY AND DEPENDENT COVERAGE

Automatic Enrollment for Employees

Under the PPACA, any employer with 200 or more employees that offers enrollment in one or more health benefit plans shall automatically enroll new full-time employees in one of the plans offered (subject to any waiting period authorized by law) and to continue the enrollment of current employees. Any automatic enrollment program shall include adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee was automatically enrolled in. The rules for such program shall be incorporated by reference once they are issued. It is important for employees to enroll within 30 days of their eligibility date.

Eligible Employees Defined

- For purposes of the Plan, the term "member" is used to refer to the primary member who is the eligible employee or eligible retiree and not their eligible or covered dependents. Specific rights or benefits that are designated as applying to the "member" are used to refer to the primary member (i.e., certain wellness benefits). Covered dependents or spouses only have individual enrollment rights and benefits as specifically provided under COBRA to "qualified beneficiaries."

- Eligible employees and retirees shall be those groups of employees as identified in the applicable collective bargaining agreement(s). The collective bargaining agreement(s) shall be incorporated herein by reference.

Legal Separation or Divorce, COBRA Rules Apply

In the case of a legal separation or divorce, spousal coverage is automatically terminated as of the last day of the month in which the court approves the legal separation or divorce. Coverage can only be continued under COBRA for up to 36 months following the month the legal separation or divorce occurs. Coverage for a legally separated spouse cannot be continued under family coverage once there is a legal, court-approved separation or divorce.

COBRA premiums for a legally separated spouse must be paid from the beginning of the COBRA period. All past due premiums must be paid within 60 days of the date the COBRA election notice is mailed if the event is not timely made.

Court orders are not binding and cannot change any Plan or COBRA rules. However, a Court order can attach financial and legal responsibility for providing health coverage and the Plan and school district will enforce the order to the extent it is consistent with and does not violate Plan rules. Payroll deductions will be made to comply with any order that requires a member to maintain spousal or dependent coverage. In no event can any court order extend coverage beyond that required by law under COBRA rules.

A divorced spouse of a retiree who is at least age 55 and has been covered for at least five (5) years may continue coverage for their lifetime. No coverage, other than COBRA, is available for dependents.

Medicare Enrollment Required When No Longer Covered Under an Active Employee's Plan

At age 65 and when a surviving spouse is eligible for Medicare Part B, they should consider which options are best for them. After one attains age 65 and is eligible for Medicare Part B, you should compare all your options including Medigap coverage, Medicare Advantage Options for your area as well as your prescription drug coverage. The cost of this Plan will continue to be the same as the COBRA cost for any terminating employee. The cost of this coverage will typically be higher than other options available to you. It is important for you to reach these decisions during the initial enrollment period (3-months prior to the month you attain age 65) for Medicare Part B.

Generally, you are required to enroll in Medicare Part B when first eligible, which is the first day of the month in which you attain age 65. You should enroll at least 30-days prior to that date. The initial enrollment period for Medicare is the three-month period prior to the month in which you attain age 65 and the three-month period following the month in which you attain age 65. Enrollment in Part B may be deferred until the following:

a. If you are only covered under your spouse's plan (this plan), the date your spouse retires.

b. If you have your own coverage, the date you retire unless your spouse is active at work, and you are also covered under your spouse's plan.

c. If you have your own coverage by reason of your own employment, and you are also covered under your spouse's plan, you are required to enroll in Medicare when you both retire, and you are no longer covered under a plan of an active at work employee.

Dependent Coverage to Age 26 (Retroactive Enrollment Not Permitted)

The Working Families Relief Act of 2004 requires that all welfare and pension plans comply with the definition of a dependent as modified and defined under IRC §152. While the dependent rules for tax purposes have not been changed, they now only apply to dependents under age 19 and disabled dependents after they reach the maximum age to be covered as a "child" as defined for purposes of Code §105(h) as amended by the Patient Protection and Affordable Care Act.

In accordance with the Patient Protection and Affordable Care Act, including Reconciliation Act (Health Care Reform) changes and amendments thereto, both married and unmarried children may be covered to age 26. These rules shall be effective the first day of the Plan Year on or following September 23, 2010,

unless the Plan specifically elects to implement this rule prior to the required date. This plan was modified to permit coverage of full-time students to age 26 effective July 1, 2010. Non-students aged 19 to 26 may be added and covered as of the first day of the Plan Year for the respective Plans.

“Child" includes children, stepchildren, legally adopted children (must be adopted prior to age 19), children placed with the employee for adoption, and eligible foster children, and children for whom you are the legal guardian, or a child whose legal custody is transferred to the Employee or the Employee’s spouse pursuant to a court order or decree and who is claimed as a dependent or can be claimed on your tax return.

Please see the Dependent Notice in Part C for dependent coverage to age 26.

Rescission of Coverage

Generally, coverage may not be terminated retroactively. 30-day advance notice is required. The plan sponsor cannot terminate coverage effective with a date in the past if:

- The member was covered through plan error, and
- The member paid premium or contributed to the cost of the Plan.

In these cases, the plan sponsor can only terminate the member’s coverage with a future effective date of termination.

The plan sponsor may terminate coverage retroactively as part of a monthly reconciliation of eligibility data if:

- The member did not pay any premium or contribution for coverage past the termination date.
- The plan sponsor also may terminate coverage retroactively in cases of fraud or intentional misrepresentation. In these cases, a 30-day written notice of coverage termination is required, and the rescission of coverage may be appealed.

Here are some examples:

- The plan sponsor finds they mistakenly enrolled a part-time employee who was not eligible under their plan. The employee paid premium/contribution, received medical services, and submitted claims. Under the new law, the plan sponsor can terminate this employee’s coverage, but only with a prospective (future) termination date.
- A member’s employment was terminated, and the employee did not make any payment of premium/contribution toward his benefits after he left the job, but this Plan was not notified about termination of coverage until a few weeks later. In this case, the plan sponsor may terminate benefit coverage as of the employment termination date.
- The Plan does not cover divorced ex-spouses, but an employee fails to notify the plan sponsor about a divorce for a period of time. If the employee or ex-spouse did not pay premium/contribution toward the benefit, the plan sponsor may terminate the ex-spouse’s coverage retrospectively.

  Note: Plan rules provide that the member is responsible for (1) paying the COBRA premium for any month’s an ineligible spouse or dependent was covered due to fraud, misrepresentation, including the failure to notify the Plan of a change in family status or (2) reimbursing the plan for claims incurred.

Retroactive enrollment is not permitted

Only “enrolled” children or dependents shall be covered. After the initial enrollment period under Health Care Reform (HCR), dependent coverage may only be changed during the annual open enrollment period, unless there is a special event. For example, your child becomes covered by their employer, and you do not wish to cover your dependent under your plan, or your dependent loses their health or dental coverage due to job loss or divorce. Full-time students and enrollment as Out-of-Area will not be permitted unless timely enrollment and student status information is submitted as required (January 31 for the spring term and September 30 for the fall term). Status changes which qualify as a Special Enrollment must be submitted

within 60 days of the event. Otherwise, no changes may be made until Open Enrollment. The effective date of coverage will be the first day of the month or the date the enrollment is received as provided in Part A of the Plan.

Disabled Child

A disabled child means a dependent child who is, or has been, totally and permanently disabled prior to this Plan *(or while covered as a dependent under the Plan as designated in Part A)* and is unable to earn a living can continue to be covered as a dependent. Satisfactory written proof of such incapacity and that the child is solely dependent on the employee for support must be provided within 90-days of the child's 19th birthday or date of disability if such disability begins while covered after age 19 and prior to age 26. After age 26, medical and Rx coverage may no longer be continued once the child is eligible for Medicare.

A disabled Child must be dependent on you for financial support, as defined by the Internal Revenue Code, and the covered employee must declare the child as an income tax deduction. The employee must provide proof that the child is incapable of self-sustaining employment within 30 days of the child reaching the limiting age of the Plan. The disabled child must meet the above support requirements.

The Plan may require the employee to furnish periodic proof of the child's continued incapacity and dependency after the child's 26th birthday *(but not more often than annually).* If the proof is not satisfactory to the Plan, coverage for the child will end immediately. This provision will also apply to any dependent who is disabled at the time the employee becomes eligible for coverage under the Plan, provided the dependent was previously covered as a disabled dependent under the employee's prior coverage. Proof of prior coverage (HIPAA Certificate) is required at the time of enrollment.

Grandchildren

Grandchildren are not eligible dependents unless the primary member or their spouse has guardianship or legal custody of such child and is responsible for over half of the child's support and the child resides on a full-time basis with the member and their spouse (if any). Generally, the child must be claimed as a dependent or eligible to be claimed for tax purposes unless the member waives that right in favor of a natural parent. These rules shall apply to any other child over whom the member has legal guardianship or custody, for example a niece or nephew. Such child shall be treated the same as any other dependent child for the purposes of this plan.

Newborns/Adopted/Foster Children

A child born to an employee, while the employee is insured under the Plan, is considered an eligible dependent. Documentation of birth *(birth certificate and social security number)* is required as soon as possible following the birth or adoption of a child. Coverage on the infant will be effective as follows:

1. **The moment of birth for a natural child, provided an employee timely enrolls the child.** If the newborn or dependent is not timely enrolled, they may not be added until the next open enrollment period**.**
2. **If family coverage is in effect prior to birth, a child is automatically deemed enrolled; however, documentation of birth and updated enrollment information on the newborn is still required** *(birth certificate and Social Security number).* Failure to provide a birth certificate and Social Security number may delay payment of claims.
3. **If single coverage is in effect, the dependent child must be enrolled for coverage within 60-days *(two months)* of birth to be covered from the date of birth.** Once dependent or family coverage is in effect, any additional newborn dependent will be covered automatically at birth without any requirement that they be enrolled. However, the employee must provide the Plan with a copy of the birth certificate and social security number before claims can be paid for the dependent *(provide a copy of the birth certificate and social security ID).*
4. **From date of adoption or placement in the home of a foster child, provided family or dependent coverage is applied for within 60-days *(two months)* of adoption or legal custody**. Adopted children *(including a child born of a surrogate mother or a child whom the employee*

obtains custody) can be covered on the date the child is placed in the home, or the date the adoption or custody is legally effective (see 1993 Omnibus Reconciliation Act, effective August 10, 1993.)

5. **An infant will be covered from the date of birth, or the date the Participant *(member)* timely applies for family coverage, and assumes total or partial support of the child, including medical expenses**. The child placed with the member terminates when the legal duty to provide for the child's care terminates. If liability for medical costs is assumed prior to the child's birth, and family coverage is also effective prior to birth, the infant will be covered at birth and no pre-existing condition rules will apply.

6. **If a claimant covered under the Plan acts as a surrogate mother on behalf of someone not covered by the Plan, ANY payments received for acting as a surrogate mother, regardless of who is paid, will FIRST be used to pay for any medical expenses associated with the pregnancy.** No maternity expenses associated with the birth of a child will be covered under the Plan, unless the mother is a covered member or dependent. A newborn of a dependent child may not be covered under the Plan, except under COBRA, or as a legal dependent of the member employee or spouse.

7. **If the employee enrolls a dependent for coverage as soon as he/she is eligible, insurance for the dependent will begin on the same date as the employee's own insurance.** An employee can cover a dependent on the date the dependent is acquired if coverage is applied for within 60 days. Otherwise, a child can only be covered under late or special enrollment rules, or during open enrollment.

8. **Only enrolled dependents are covered as listed on the member's enrollment form.**

Foster Children

Foster children may be covered in accordance with the Health Care Reform Act, as amended, the same as any other dependent. The plan must be notified within 60 days of the placement of a foster child. Otherwise, the child may not be added until the next open enrollment period, or as the result of a Qualified Medical Child Support Order (QMCSO).

Special Rules for Newborns of Dependent Children (must enroll within 30-days)

Dependent, unmarried daughters are covered for any pregnancy-related benefit. However, children of a dependent child will not be covered under the Plan, unless the dependent child is eligible for, and coverage is elected on behalf of the child under the Plan's continuation rules (COBRA) within 30-days of the date of birth. If the child (grandchild) becomes a legal dependent of the employee or employee's spouse, they can be covered as their legal dependent. The COBRA date of the event will be the birth of the child and COBRA premiums will begin as of the first day of the month following the birth of the child. If COBRA is not elected and the newborn is timely enrolled, the newborn will be covered for the first 30-days of birth only.

Single Coverage versus Family Coverage

Single coverage provides maternity benefits for the covered female employee only. Family coverage provides benefits for all eligible dependents, including newborns, per Plan rules, and spouse, if any. Coverage provides maternity benefits for a spouse, or any dependent unmarried daughter(s), who is a dependent under the Plan. (See eligibility and dependent coverage rules.)

Collective Bargaining Agreement

If this Plan covers employees subject to collective bargaining, any collective bargaining agreement covering such employees is incorporated herein by reference, along with any subsequent amendments or modifications to the agreement and any operating policies maintained under the agreement.

This Plan is subject to any specific rules as set out in the collective bargaining agreement governing eligibility, leaves of absence (including a leave required by the Family Medical Leave Act (FMLA), opt-out rules, employee premiums for active employees and retirees, retiree coverage, and eligibility for benefits. The collective bargaining agreement for covering employees who are or who become eligible to participate in the Plan, will be incorporated by reference and will apply with respect to the cost of coverage,

leave of absence, opt-out coverage, dual coverage rules, and any other rules as set out in such agreement(s).

In the event of dispute, any specific Bargaining Agreement terms will prevail over the terms of this Plan. If the bargaining agreement does not address the situation, Plan rules will apply.

Employer Responsible for Notifying Trust of Certain COBRA and Other Personnel Events

The Employer is responsible for notifying the Plan and COBRA Administrator of any COBRA event that they are aware of, including voluntary and involuntary terminations, layoffs, and any approved leave of absence, including notification as to whether a leave of absence is with or without benefits. Any leave of absence, not subject to or extending beyond FMLA rules, will be presumed to be without benefits and a COBRA event, subject to the continuation of benefit rules under COBRA. The plan sponsor is responsible for timely notifying the Plan of all personnel actions, including new hires, layoffs, reinstatements, and COBRA events (terminations, military leave, leave of absence) as required by COBRA rules and regulations. In the case of a trust that is the subject of collective bargaining, the employer has a fiduciary duty to inform the Plan of new hires and COBRA events on a timely basis.

Administrative Error

If failure to enroll is due to an administrative error, coverage will be effective dependent upon the facts and circumstances of the situation. Examples: (1) A part-time employee, who was previously ineligible for coverage, becomes a full-time employee and is inadvertently not given an opportunity to enroll in the health Plan; or (2) The original enrollment forms are lost in the mail and the error is not discovered until a later date. Any cancellation or rescission of coverage due to failure to meet the eligibility rules of this Plan shall be subject to the rescission/termination of coverage rules under the Health Care Reform.

Documentation of the administrative error must be provided by the Employer or Plan Administrator and will be subject to approval by the Plan. Payment of all back premiums for the cost of coverage is the responsibility of the employer. In the event of administrative error, the employee will be deemed enrolled as of the date when he/she was first eligible upon approval by the Plan.

In the event the administrative error is failure on the part of the employer to notify the Plan Administrator that coverage has been changed, terminated, or a death has occurred, the change will be made retroactive to the date of the event. No retroactive adjustment in cost will be made to the employer, if any, beyond two (2) months. For the purpose of COBRA, the cost of COBRA coverage will be deemed to have been paid by the employer for the period prior to delivery of the actual notice of an event, at which time a COBRA notice will be provided to the affected member(s), if appropriate. All decisions in this regard rest solely with the Plan and will be made in an equitable manner. When there is any doubt resolution will be in the favor of the member.

Under no circumstances will the COBRA election period extend beyond that required by law measured from the actual date of an event, including situations when the COBRA notice is mailed out late due to administrative error or failure to notify the Plan Administrator of a COBRA event. Exception: Any child covered pursuant to a QMCSO will be covered retroactively, without evidence of insurability.

Eligible Retired Employee

Eligible retirees can elect to continue coverage with the Plan. For retired members, this Plan will be primary until you become eligible for Medicare, unless your spouse is actively employed and has other coverage with another employer as an active employee, then Medicare Secondary Payor (MSP) rules apply once you are eligible. For retired spouses, their own retiree coverage, if any, is primary until they are eligible for Medicare, except when the Medicare Secondary Payor Rules apply. Once Medicare is effective for you and/or your spouse, this Plan will become secondary, except in a situation when you are covered as the active employee or as a dependent under an actively employed spouse under the MSP rules. Members are responsible for notifying the Plan of all other health coverage, as an employee or retiree for themselves as well as any other covered member including spousal coverage. Verification of Medicare enrollment (a copy of the Medicare ID) is required for any covered individual.

Eligible retirees for any teacher group covered by this Plan in the state of New York shall include:

a. Employees eligible to retire under the New York State Teachers Retirement System;

b. Employees eligible to retire under the New York State Employees Retirement System; or

c. Employees who are eligible for retirement as determined by the Plan.

Retired employees can continue their own coverage and their spouse's coverage as long as they are living and remain married and are not legally separated or divorced. If a retiree has dependents including his/her spouse, coverage will continue as family coverage. The following special rules apply to retiree coverage and changes in coverage after retirement. All benefits under the Plan are subject to the right of the Plan to be amended or modified at any time by the Trustees or as a result of changes in the collective bargaining agreement.

Upon the Death of a Retiree's Spouse

If the retiree 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 only be added during any open enrollment as a special enrollment situation.

Adding Dependent/Spouse at Time of Retirement

If a retiree has single coverage in effect at the time of retirement, he/she can still add spouse and/or dependent coverage within 60-days of the date of acquiring new dependents or as a special enrollment situation. Otherwise, new dependents may only be added during any open enrollment.

Extended Coverage for Certain Divorced or Widowed Spouses of Retired Members

COBRA coverage is available, subject to COBRA rules for the first 36 months for any spouse who would lose coverage on account of divorce or death. The initial COBRA period can be extended under this Plan, subject to the following rules:

1. If the divorced spouse has been married to the retired member for five (5) or more years, been covered under the Plan for five (5) or more years, and is at least age 55 or older, coverage can be continued at COBRA rates for the spouse's lifetime, as long as the Benefit Trust remains in effect; or

2. A widowed spouse of a retired member can continue COBRA coverage for his/her lifetime following the death of a retired member, at COBRA rates.

If the spouse remarries, he/she cannot add any additional dependents or a new spouse to the coverage after the initial COBRA period (36 months) expires. During the initial COBRA period, the spouse can add a new spouse or dependents, but they may only be covered during the initial COBRA period and are not eligible for extended Coverage beyond the initial COBRA period. COBRA rules, with respect to payment and lapse of coverage will continue to apply to extended COBRA coverage under this paragraph. The member must request continued coverage under this option and make monthly payments to retain continued coverage, subject to COBRA rules. Dependent children covered at the time of the event (qualified beneficiaries) would be eligible for continued coverage after the initial COBRA period only if family coverage is maintained.

Coverage Rules While on Leave of Absence

Employees who are on an authorized leave of absence, as approved in writing by the board and provided in this Plan, are subject to the terms of the collective bargaining agreement (which may be amended from time-to-time and is incorporated herein by reference) will continue to be eligible for group health or dental coverage and other benefits, the same as any active employee, provided they continue to pay any employee portion of the cost. This applies to any of the following approved leaves of absence. There is no requirement that any of the following leaves run concurrently with any other leave, except for sick leave and Workers' Compensation leave. The district will continue to pay for full coverage while the member is on paid leave or Family Medical Leave (FMLA) under Federal Law, including Workers' Compensation leave.

The member is responsible for paying their own premiums (102% of the COBRA rate) while on unpaid leave without benefits, including any family leave that is unpaid and does not qualify for FMLA leave under

Federal Law. COBRA will not begin until the end of any paid or unpaid leave that has been approved by the district or when the employee fails to return from an approved leave of absence.

Employee status will be retained while on any paid leave pursuant to the Collective Bargaining Agreement(s) with this Plan or any approved leave, as follows:

1. Family Medical Leave (FMLA) under Federal Law (paid or unpaid) up to a maximum of 12 weeks when group health benefits are continued;
2. Child Care Leave (without pay following FMLA leave) will be granted for up to two years. Benefits can only be continued under COBRA;
3. Paid Sick Leave for any personal illness or any other family situation, as approved by the district, and any paid leave from the Sick Bank that could be granted to teachers when group health or dental benefits are continued pursuant to the collective bargaining agreement, and/or the policies adopted thereunder;
4. Any Workers' Compensation leave when group health or dental benefits are continued pursuant to the collective bargaining agreement, and/or the policies adopted thereunder; or
5. Any other leave, approved by the District, including a disability leave of absence, in excess of that required under FMLA, pursuant with the Collective Bargaining Agreement.

MEDICARE COORDINATION OF BENEFITS

The following provisions explain how the Plan's group health benefits interact with benefits available under Medicare. A covered person may be eligible for Medicare by reason of age, disability, or End-Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as shown below.

Failure to Abide by Medicare Rules for HMO or PPO Providers: If you fail to abide by the rules, with respect to one of the special HMO or Regional PPO plans offered by Medicare, the maximum benefit paid under the Plan will be limited, as provided under the coordination of benefits rules for any service that would otherwise have been covered. Non-Medicare expenses will be provided on the same basis for any other plan member or beneficiary.

Group Health Benefits: Any dental, medical, prescription drug and surgical coverage provided by the Plan.

Large Group Health Plan (LGHP): A plan that covers 100 or more employees. Special rules apply to LGHP for purposes of Medicare coordination that requires a plan covering an individual as an employee or a dependent of an employee, who is considered to be actively at work, will always be the primary plan to Medicare.

Medicare Coordination: Benefits from the Plan will be coordinated with Medicare regardless of whether you are enrolled in the traditional Medicare indemnity plan, a Medicare HMO, or regional Medicare plan, or if you use the Medicare private contract payment option. Even when benefits are coordinated, the health plan will only pay those charges that are specifically provided for in its official provisions. All limitations, exclusions, and benefit maximums apply to the payment of any benefit coordinated with a benefit from any other plan.

Medicare Eligible: A covered person is considered eligible for Medicare by reason of age from the first day of the month during which he/she reaches age 65. However, if the covered person is born on the first day of the month, he/she is considered eligible for Medicare from the first day of the month, which is immediately prior to his 65th birthday. Any member of the Plan will automatically be "enrolled" in Medicare, Part A, if they have filed for Social Security Benefits when first eligible regardless of whether they actually enroll. Individuals who have been disabled under Social Security for two years are also eligible for Medicare benefits.

Enrollment in Medicare Part A and B is required under the terms of this Plan once you are retired or eligible on account of disability. This rule applies to covered spouses and disabled dependents.

Medicare Private Contract Option: Under Medicare, if your doctor refuses to accept a Medicare payment (even if you submit the claim to Medicare), or refuses to bill Medicare, he/she is considered a Privately Contracted Doctor or Contract Provider and you are totally responsible for 100% of all charges as billed. If you are eligible for Medicare and use a Private Contract provider, the Plan's benefits will be limited to what the Plan would have paid if you had used a Medicare Provider, and you will be responsible for any balance. Use of a Private Contract provider will significantly reduce your Plan benefits.

Primary Plan: The health plan pays benefits first for a covered person's charges and ignores what the covered person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. (See the Plan's "Coordination of Benefits" provisions.)

MEDICARE ELIGIBILITY BY REASON OF AGE

Rules Apply to

An employee or his/her covered spouse that is eligible for Medicare by reason of age. Under this section, an employee or covered spouse is referred to as "Medicare Eligible." This section does not apply to: (a) a covered person other than an employee or covered spouse; (b) an employee or a covered spouse under age 65; or (c) a covered person who is eligible for Medicare solely on the basis of End-Stage Renal Disease.

When You Become Eligible for Medicare

Under Medicare rules, a member becomes eligible for Medicare the first day of the month in which they attain age 65, unless your birthday is the first of the month, then your initial month of coverage is the month preceding your 65th birthday. Medicare must be elected at that time unless an employee or their spouse remains employed beyond age 65.

- Election of Medicare can be deferred until the active at work employee with medical coverage retires with no penalty as long as they are covered as an employee or dependent of an active employee.
- When you are within six (6) months of age 65, we recommend that you verify all your options prior to electing Medicare.

This Plan is primary for any spouse or dependent of a covered member who is eligible for Medicare if the employee is actively employed and has group health coverage. The reverse is true if the spouse is actively employed and has coverage on this plan's member who is Medicare eligible. Please refer to the COB Chart in Part A.

If a Medicare eligible chooses Medicare Part D, other than the KTF Part D, as his/her primary Prescription Drug Plan, he/she will no longer be covered for Rx benefits under this Plan. Rx coverage under this Plan will end on the date the Medicare eligible elects Medicare Part D as his/her primary plan. See Addendum #2, Notice of Creditable Coverage, which explains your rights under the Medicare Part D Prescription Drug Program.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to an employee who: (a) is under age 65 and eligible for Medicare by reason of disability; and (b) is a deemed employee under Federal Law, if at least one of the following applies. This section also applies to a covered dependent of an employee who is: (a) under age 65; and (b) is eligible for Medicare by reason of disability. This section does not apply to: (a) a retired employee who does not fall into any of the categories listed above; (b) a covered person who is eligible for Medicare by reason of age; or (c) a covered person who is eligible for Medicare solely on the basis of End-Stage Renal Disease.

1. He/she is an active employee;
2. He/she receives wages from the employer from whom FICA taxes are collected, or from which FICA taxes would be collected, except the employer is not required to pay such taxes under the Internal Revenue Code;

3. He/she is termed an employee under Federal or state law, or by a court decision;
4. The employer pays the same taxes for him/her as he/she pays for active working employees;
5. He/she continues to accrue vacation time or receives vacation pay;
6. He/she participates in an employer's benefit plan in which only active employees can participate;
7. He/she has the right to return to active work if his/her condition improves; or
8. He/she continues to accrue sick leave.

When You Become Eligible for Medicare

Generally, Medicare A and B is automatically effective as of the first day of the 25th month following your Social Security or Railroad disability date or the date when you are diagnosed as end stage renal disease and go on dialysis, or you are diagnosed with ALS.

Medicare Eligibility for End-Stage Renal Disease (ESRD)

This section applies to a covered person who is eligible for Medicare solely on the basis of End-Stage Renal Disease (ESRD). A covered person is referred to as "ESRD Medicare eligible." This section does not apply to a covered person who is eligible for Medicare by reason of age or disability.

When a person, who is actively employed or covered under the Plan of a member who is actively employed, becomes eligible for Medicare solely on the basis of ESRD, the Plan will be the primary plan for the initial consecutive 30-months for benefits paid for the treatment of ESRD, by both the Plan and Medicare. The Plan will pay first, ignoring Medicare. Medicare is considered the secondary plan.

The 30-month consecutive period begins the earliest of:

1. The first day of the month during which a regular course of renal dialysis starts; and
2. With respect to an ESRD Medicare eligible member who receives a kidney transplant, the first day of the month the covered person becomes eligible for Medicare.
3. After the 30-month consecutive period (described above) ends, if an ESRD Medicare eligible member incurs a charge for which benefits are paid under both the Plan and Medicare, the Plan supplements what Medicare pays. Benefits paid by Medicare are subtracted from what the Plan would normally pay. If a covered person is eligible for Medicare solely on the basis of ESRD, Medicare Part A and B must cover him/her. If he/she is not, he/she must meet the Medicare Alternate Deductible. The Medicare Alternate Deductible is equal to the Cash Deductible, and what Part A and B of Medicare would have paid had the covered person been insured. Please refer to the Medicare publication, ***Medicare and Other Health Benefits: Your Guide to Who Pays First***.

When Does Medicare Become Primary?

The ultimate determination of when Medicare becomes primary depends on the facts and circumstances of each situation. Generally, Medicare will pay secondary to any coverage under an active at work employee. When Medicare is due to ERSD or ALS, employer coverage, including coverage under COBRA, is required to be primary for 30-months. There are situations where an individual may be considered as a "dual eligible" employee where they are entitled to both Medicare and Medicaid. Please contact the Compliance Office for a final determination. The Compliance will work with the Medicare Coordination of Benefits Contractor to reach a final determination.

PROHIBITED DISCRIMINATION UNDER MEDICARE

Employers must offer disabled Medicare beneficiaries the opportunity to reject LGHP coverage. If LGHP coverage is rejected, Medicare becomes the primary payor. In the case of disabled employees who are actively at work, the employer must not offer to subsidize supplemental (Medigap) coverage, except for items and services wholly uncovered by Medicare (for example, prescription drugs and eyeglasses). However, beneficiaries who reject the LGHP can purchase Medicare supplemental coverage from a source

other than the employer. It is considered discriminatory against the working-aged or the disabled, and therefore prohibited, if an employer:

1. Fails to make primary payment, or makes a smaller payment, on behalf of someone for whom Medicare is the secondary payor;
2. Terminates coverage for employees or spouses aged 65 or over because they have become entitled to Medicare;
3. Treats younger employees and spouses differently;
4. Refuses to allow employees or spouses aged 65 or over to enroll, or to re-enroll, on the same basis as younger employees and spouses;
5. Imposes a separate limit on benefits, or implements separate exclusions or reductions in benefits for those age 65 or over; and
6. Imposes higher premiums, higher deductibles, or coinsurance, longer waiting periods, lower annual or lifetime benefit limits, or more restrictive pre-existing illness conditions for persons aged 65 or over.

Important Note: The employer must inform an employee and their spouse, who are entitled to Medicare, that they can reject coverage under the Plan and choose Medicare as their primary payor. If they reject coverage under the employer's Plan, the employer cannot offer to subsidize a plan intended only for items and services for which Medicare provides no benefits (for example: prescription drugs and eyeglasses) to active employees. Beneficiaries who reject the employer's plan can purchase Medicare supplemental (Medigap) coverage from a source other than the employer. The employer cannot purchase or subsidize an individual supplemental policy for the employee or family member.

The benefits provided must not differ in any way from the benefits provided to persons who do not have permanent kidney failure. This nondiscrimination requirement applies during and after the period when Medicare is the secondary payor, whether a person is entitled to Medicare.

Example: Any member with permanent kidney failure, with or without Medicare, both during and after the 18-month period, the Plan cannot:

1. Refuse to allow an individual with permanent kidney failure to enroll, or to re-enroll, in the Plan on the same basis as a person who does not have permanent kidney failure;
2. Fail to cover routine kidney dialysis services or kidney transplants at the same level as other services covered by the Plan;
3. Impose separate limits on benefits, reduce benefits, or impose separate exclusions on enrollees who have permanent kidney failure; or
4. Impose higher premiums, higher deductibles, or coinsurance, longer waiting periods, lower annual or lifetime benefit limits, or more restrictive pre-existing illness conditions on enrollees who have permanent kidney failure.

A large group health plan (LGHP) cannot discriminate against any disabled Medicare beneficiary when Medicare is the secondary payor. This means, it must not treat these enrollees any different from other enrollees because they are disabled and have Medicare. With respect to those disabled Medicare individuals, an LGHP cannot:

1. Fail to make primary payment, or make a smaller payment, on behalf of someone when Medicare is the secondary payor;
2. Terminate coverage on the basis of entitlement to Medicare;
3. Provide different benefits, or a different level of benefits on the basis of entitlement to Medicare; or
4. Charge a higher premium than the premium charged to other enrollees in the plan.

Employer Responsibilities and Penalties under the Medicare Secondary Payor (MSP) Program

Non-conforming group plans will be reported to the Internal Revenue Service (IRS). The IRS is required to impose a tax on employers or employee organizations that contribute to those plans. The tax is equal to 25% of all contributions made to all group health plans during the year. For information on Medicare, request a copy of the Medicare Handbook from your local Social Security Office, or call the Medicare Hotline at (800) 820-1202. Under the Medicare Secondary Payor (MSP) law, employers adhere to the following rules:

1. Identify individuals to whom the MSP requirements apply;
2. Provide for proper primary payments when the law makes Medicare the secondary payor;
3. Assure there is no discrimination against employees and their spouses aged 65 or over, people who suffer from permanent kidney failure, and disabled Medicare beneficiaries when Medicare is the secondary payor; and
4. Meet the reporting and disclosure requirements of the 1993 Omnibus Reconciliation Act and Medicare Data Bank.

Medicare Coordination

Once Medicare is primary, the Plan is intended to provide secondary coverage to supplement Medicare and to cover expenses not covered by Medicare for the covered member, spouse, or dependent. Plan benefits are limited under COB rules, depending on the providers used and the services provided. Plan benefits will fall in one of the following four (4) categories. In no event will the total paid amount exceed allowable charges. This Plan's allowable charges are based on the largest of the Medicare allowable charges or the KTF contractual rate. Benefits are determined by the type of provider after normal deductibles, copays, or coinsurance. (See Special Rules for Medicare Coordination under the Coordination of Benefits sections above.) Benefits are covered for each of the following situations when services are provided by:

1. A Provider Who Accepts Medicare Assignment of Benefits: Benefits will be fully coordinated leaving little or no financial responsibility for the covered member;
2. A Medicare Provider who bills Medicare but does not accept Assignment of Benefits from Medicare: Benefits will be fully coordinated leaving little or no financial responsibility for the covered member;
3. A Contract Provider Not Covered by Medicare: Medicare will not pay benefits, benefits under the Plan are limited, and members have considerable additional financial liability for services provided by contract providers. These rules apply if you enroll in a non-traditional Medicare Program (Regional HMO or PPO Plan); or
4. Benefits Not Covered by Medicare: Benefits will be covered by the Plan as though it were the primary plan.

Creditable Rx Coverage is Provided under the Plan

The Plan provides creditable Rx coverage for the Medicare Part D Prescription Drug program. If you elect one of the Medicare Part D Prescription Drugs programs, other than the KTF Part D, there will be no coordination of Rx benefits under the Plan. Your Rx coverage will be The Plan or the Medicare Part D Plan. You can change this election at any time per Medicare enrollment rules. Open enrollment for Medicare Part D is each November.

PRE-CERTIFICATION AND CASE MANAGEMENT

Alternative Benefits Approved Under Case Management

If a special treatment program is approved that would not otherwise be covered under the Plan, due to extenuating or unusual circumstances, benefits paid by the Plan will be paid at 80% in network and 70% out-of-network.

Approval under case management will generally be based on the potential long-term savings in overall medical costs to the Plan as well as the long-term prognosis of the patient's condition. **Alternative benefits will be determined at the sole discretion of the Plan, based on all facts and circumstances with respect to each situation. Member coinsurance will not be subject to nor credited toward the out-of-pocket (OOP) limit for an alternative program.**

In order to take into consideration an alternative course of treatment, the recommendation of the patient's provider must be provided, which includes the prognosis and diagnosis of the patient along with why the treatment is being recommended. The primary member must agree to the alternative program and accept full responsibility for their portion of the charges as a condition of approving such treatment. All treatment will be subject to ongoing concurrent review and case management, typically on a weekly basis, and extended care will be subject to favorable progress by the patient. If the patient is non-responsive or non-compliant, the program can be discontinued.

Case Management

When extensive treatment is expected, due to an illness or injury, the member will be assigned a case manager to follow up with the providers and the member to ensure that appropriate medical treatment is provided and to determine the progress of treatment. Case management is a tool used by the Plan to determine whether extended benefits are appropriate and medically necessary or if alternative treatment is appropriate. Any extraordinary or extended benefit approval of out-of-network providers, on a case-by-case basis, can only be provided when the member and his/her family cooperate fully with the case manager.

The Plan reserves the right to cover *"alternative"* or *"extended"* treatment that is not specifically covered by the schedule of benefits but is deemed medically necessary and/or cost effective for the Plan due to a serious or chronic condition with potential long-term treatment. In such situations, the Plan will agree to pay a percentage of the cost between 60% and 100% based on the facts and circumstances of each situation. The employee's portion of the cost will generally not be applied toward or subject to the out-of-pocket limit and the member must agree to the terms of the program.

Case management nurses are immensely helpful to plan members and can assist the members in the course of their treatment program. They can advise members of available network specialists and providers or assist members by negotiating with out-of-network providers to secure contractual discounts, which will lower plan costs for both the member and the Plan. Case management is not used as a tool to prohibit treatment, override recommendations by your doctor, or to deny coverage. It is used to monitor medical necessity and eligibility for certain benefits. Extended benefits or special benefit programs are subject to case management approval and require cooperation and communication with the case manager, as requested. Any extension of a benefit or approval of alternative treatment beyond the benefit specifically provided is at the sole discretion of the Plan.

Concurrent Care Decisions

If the Plan has approved an ongoing course of treatment to be provided over a period of time, or number of treatments, any reduction or termination by the Plan (other than by plan amendments or termination) before the end of such period of time or number of treatments will be considered an Adverse Benefit Determination. The Plan will notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Any request by a claimant to extend the course of treatment beyond the period of time, or number of treatments, for a claim involving urgent care, will be decided as soon as possible, taking into account the medical exigencies. The Plan will notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Benefits will not be paid for services rendered once continued care or treatment is denied due to failure to meet the medical necessity rules under the Plan and such determination is made following a peer review by an independent review organization. In the case of an internal denial with no review

by an IRO due to medical necessity, benefits will continue during the appeal process or until there is a decision by an Independent Review Organization (IRO).

General Pre-certification and Case Management Rules

Pre-certification and case management are two tools used to help provide quality care while managing costs. Pre-certification is neither a guarantee of eligibility nor a guarantee of Plan payment. Benefit payments and eligibility for benefits are determined at the time the claim is processed. Failure to timely file a claim may make a provider and member ineligible for any benefit. If a plan member is planning or is scheduled to undergo surgery, prior approval is required in accordance with the pre-certification rules in Part A. This also applies to outpatient surgery, any confinement, or hospitalization program. The Utilization Review (UR) firm listed on the ID card and the cover page of this booklet must be contacted (phone numbers are on the ID card) and written requests and reports must be mailed to the appropriate firm. The Plan reserves the right to change the UR firm at any time.

Medical Necessity

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 services and supplies necessary to adequately diagnose and treat an illness or injury (including maternity care or emergency care), per standard medical practice. Appropriateness of medical care is also included in determining medical necessity and must be consistent with the diagnosis and treatment of the 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, 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 in a timely manner, per the provider's policy.

Behavioral and Addiction Care:

The level of care criteria that follows the guidelines for determining medically necessary treatment based on DSMIV-TR disorders. 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 the medically necessary applicable criteria.

Services are medically necessary when required by a provider to identify or treat an illness that has been diagnosed or suspected and is consistent with:

A. The diagnosis and treatment of a condition;

B. The standards of good medical practice required for other than convenience; or

C. The most appropriate (supply) level of care.

All inpatient stays are based on admission criteria, severity of need, and intensity of service. Length of stay will be characterized by continued stay criteria.

Certain Treatment is Not Covered and Automatically Deemed Not Medically Necessary:

1. Any court ordered treatment including situations when treatment is agreed to by the individual in lieu of other legal/court action including fees, jail time, and public service, including voluntary treatment to reduce potential legal penalties or action.
2. Conditions that cannot be favorably changed by a specific treatment plan are not covered.
3. Long Term Care, educational care and/or training or institutional care for any medical, mental health or behavioral condition are not covered under this plan. 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

addictive conditions once maximum medical or mental health stability or psychological improvement has been reached, as determined at the sole discretion of the Plan.

4. Custodial care, including half-way houses, any shelter or facility that is not appropriately licensed by the state as a medical or psychiatric facility with appropriate medical staffing and management by a physician or psychiatrist.

See Appeals section below and Urgent Care Appeals if you do not agree with any pre-certification or case management decision made by the Plan.

Penalties for Failure to Pre-Certify Benefits

Plan benefits will be reduced for claims not pre-certified in absence of treatment or approved retrospectively in a situation when the service occurred over the weekend or holiday when it was not possible to pre-certify the service in advance of treatment. Pre-certification requirements and the pre-cert phone number are provided on the back of each member's ID card, and it is the responsibility of either the provider or member to obtain the required pre-certification. Typically, this is done by the provider as certain clinical information is generally required from the provider. **Members should verify at the time of service that their provider obtained the necessary pre-certification or approval as required by the Plan.**

No benefits requiring pre-certification will be paid if the pre-certification does not occur within one year from the original date of service. Pre-certification Penalties will not be credited toward your out-of-pocket limit. All penalties will be assessed at the sole discretion of the Plan, based on all facts and circumstances. Penalties will be assessed in accordance with the Failure to Timely File Claims and/or Pre-Certify Benefits Chart in Part A.

Pre-certification and Utilization Review Required for Certain Procedures

Please refer to Part A for a detailed list of procedures that require pre-certification. Failure to obtain advance pre-certification prior to treatment may result in reduced benefits. (See the Penalty Chart in Part A for failure to pre-certify benefits and failure to timely file claims.)

Required Information for Pre-Certification

1. Patients' name, date of birth and sex;
2. Patients' address and telephone number;
3. Patients' Social Security number and group # (see ID card);
4. Name and address of the hospital/facility;
5. Name and address of the primary/admitting physician;
6. Date of proposed admission; and
7. Reason for admission, surgery, services to be performed, and any treatment plan.

SUBROGATION OF BENEFITS

Subrogation is a type of coordination of benefits or lien designed to limit the Plan's liability when a third party is at fault for an injury or illness. The purpose of this provision is twofold. First, subrogation protects Plan assets by requiring the responsible party to cover medical expenses when a settlement of any kind occurs. Second, subrogation controls Plan costs by preventing an individual from receiving reimbursement for medical expenses from more than one source that exceeds the total cost of medical services. Subrogation prevents a covered person from receiving a settlement from a third party based on medical costs and injuries when the medical expenses were paid by a group health plan, except when there is a subrogation lien for reimbursement of the expenses. The most common type of subrogation arises from a car accident where another party was at fault. Payments for benefits under this Plan when there is third party liability for the illness or injury will only be made subject to each of the following ten conditions and the timely filing of claims rules:

1. There must be timely notice of the event (subrogation event) by the member or qualified beneficiary and timely acceptance and filing of a subrogation agreement.
2. The subrogation agreement must provide that the covered person, other insurance carrier, or third party will reimburse the Plan up to the amount of any payments made by this Plan for such injury.
3. This Plan has the right to recover in full any medical expenses paid on behalf of the covered person adjusted by a pro-rated amount of the attorney fees and expenses in relation to the total settlement (whether by lawsuit, settlement, or otherwise) that is made to the covered person by the negligent party. This applies to any benefits or compensation from a third party or parties arising out of an injury or an illness, which results directly or indirectly out of third-party liability.
4. The subrogation amount is limited to the amount received by the covered person less legal fees and expenses (net amount) from such third party or parties by way of settlement or in satisfaction of any judgment. The Plan is only responsible for paying a pro-rated share of any legal fees.
5. The Plan requires a Subrogation Agreement prior to making any payments because of an auto injury or other injury or illness involving third party liability. The member and any dependent of the member of legal age, and the attorney, must sign the agreement. The attorney must agree to hold the Plan's interest in an interest-bearing fiduciary account and to disburse the funds to the Plan upon settlement of the case (with interest from the settlement date if payment is not made within 30 days of settlement). The attorney is deemed a fiduciary and is responsible for ensuring that the terms of the subrogation agreement are met, and that reimbursement is made to the plan, as provided under the agreement.
6. In the case of late notice of the subrogation event and/or late notice of the litigation to recover from a third party, claims are deemed to include all claims attributed to the third party, regardless of when incurred or paid or when the subrogation agreement is signed. A subrogation agreement will be required as soon as the Plan has knowledge of a notice of the event.
7. As security for the Plan's right to such reimbursement, the Plan will be subrogated and have a lien against all the claims, demands, actions, and rights of recovery of the covered person against any third party or parties or his/their insurers, to the maximum extent of all payments made by the Plan.
8. In the absence of a subrogation agreement or intent to reimburse the Plan, any expenses incurred as a result of third-party liability shall be deemed to be non-covered benefits in any situation when there are any amounts received or expected to be received by the injured party directly or indirectly from the third party responsible for the injury or illness. The Plan, in such instances, has the right to request refunds from providers for previously paid expenses. Failure to dissolve any litigation or settlement constitutes fraud on the part of the covered member and the primary insured.
9. Any expenses incurred to enforce an executed subrogation agreement will be added to the subrogation amount due and will be paid by the member since advanced payment for claims is made in good faith reliance on the member and his/her attorney, automatically honoring the terms of the subrogation agreement.
10. Settlement also includes any settlement under the underinsured or uninsured portion of the member's car, home, or umbrella policy.

Member Responsibilities

The Plan and claim administrator must be notified in the event any claim is due to an injury, such as an auto accident or any other injury attributable to a third party. A claim form will be required for any accident. Expenses paid by mandatory, no-fault insurance, or similar plans, are not covered under this Plan, nor will there be any coordination of benefits for the expenses.

The following rules will apply to any subrogation situation or claim:

1. The covered person or the employee (in the case of a dependent) will execute and deliver any instruments and papers requested by the Plan. The covered person or the employee must do

whatever is necessary to execute and protect all the Plan's rights within 60-days of the subrogation notice or request;

2. The covered person must agree to do nothing to prejudice the rights of the Plan to such reimbursement and subrogation;
3. Failure to timely notify the Plan of a claim and/or to execute subrogation papers will be considered an "untimely filing of a claim." This will result in no benefits being paid or advanced under this Plan, even in the event there is no settlement or benefits paid by the third party;
4. The covered person must agree to attempt to recover the actual expenses first, prior to seeking damages for pain and suffering or other punitive damages;
5. It will be considered fraudulent practice by the claimant and/or any attorney not to allocate any settlement first toward actual expenses and damages with the balance being allocated to intangible expenses, such as pain and suffering, etc.;
6. As a condition of participation in this Plan, the claimant agrees to reimburse the Plan for any payments advanced or deemed to have been advanced if a subrogation agreement is not accepted or filed with the Plan in a timely manner, unless there is to be no attempt to seek damages (directly or indirectly) from the responsible party;
7. The Plan has the right to hold payment or to request a refund of any prior payments until appropriate subrogation papers are filed with the Plan; and
8. If Medicare is the primary plan, Medicare also enforces subrogation rules. Therefore, both your Medicare benefits and your secondary benefits with this Plan are subject to subrogation and repayment of claims will be required to both Medicare and this Plan out of any settlement. Please see the Medicare publication, ***Medicare and Other Health Benefits: Your Guide to Who Pays First***.

Subrogation is not applicable when the claim is against insurers on individual policies of health insurance issued to and in the name of the covered person. Subrogation also applies to any settlement reached under a Class Action Suit when there has been third party liability that resulted in injury or illness. Recent examples of this type of litigation/settlement have covered damages due to silicone breast implants and the damages caused from illness and injuries sustained, due to exposure to unsafe materials (asbestos).

WASTE, FRAUD, AND ABUSE POLICY

Violation of the of waste, fraud, and abuse rules as defined by law and as defined below 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. Termination of a Provider's PPO contract.
2. Denial of or reduction of a benefit payment, including charges by a PPO provider.
3. Filing a formal complaint with the appropriate licensing authority.
4. Member or Provider will be responsible for all expenses due to any action that is deemed to violate this policy, including failure to notify the Plan and your providers of all medical and/or dental coverage, including Medicare, or failure to enroll in Medicare when first eligible, including disability eligibility, when you are no longer covered under a Plan of an active at work employee.

Fraud: Health Care Fraud is defined in Title 18, United States Code (U.S.C.) §1347, "as knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program".

Waste: Waste is defined as the "intentional or unintentional, thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of resources. Waste also includes incurring unnecessary costs because of inefficient or ineffective practices, systems, or controls."

Health Care Abuse: Health care abuse may, directly or indirectly, result in unnecessary costs to the Plan, including:

- Excessive billing of charges in excess of what is normally charged by providers in the geographical area;
- Excessive billing for amounts that exceed what the provider normally accepts for full payment of their services;
- Improper payment or payment for services that fail to meet professionally recognized standards of care or services that is medically unnecessary; or
- Payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Important Notice to Members: Members are advised that 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 allowed charges. Members are advised to get an advance "quote" from the provider of the procedures or treatment, including CPT Codes, along with their cost. Contact the Compliance Office for what will be covered, and the members estimated out-of-pocket cost for such treatment or procedure.

A covered member is committing a fraudulent act if they do any of the following:

1. Fail to notify the Plan or any provider of other medical or dental insurance coverage for any covered member.
2. Failure to enroll in Medicare Part A and B when first eligible, including eligibility after 24-months on account of Social Security disability.
3. Negotiate with a provider to waive their normal copay, deductible, or coinsurance without full disclosure to the Plan.
4. Selling or giving any prescription drug prescribed to you to another individual.
5. Colluding with a provider or allowing a provider, directly or indirectly, to bill for services that were not actually provided to the covered member. Members have a responsibility to review each Explanation of Benefits (EOB) to determine what their out-of-pocket cost is and the overall accuracy of the EOB. Members should immediately contact the Compliance Office if they have any questions as to how the claim was paid.
6. Falsification of any enrollment application, including a change or failure to disclose any change in status such as a divorce or legal separation that results in the coverage of any member who is not entitled to coverage as a dependent under the terms of this Plan.
7. Failure to disclose "other" coverage in effect for any covered member.
8. Improper Coordination of Benefits (COB) information or failure to disclosure other coverage. Or any action intended to shift the benefit liability for Primary Coverage to a secondary provider.
9. Deliberate suppression of an accident or subrogation where there is third party liability.
10. Prescription forging or altering.

11. Identity theft: using another person's insurance card to obtain prescriptions.
12. Resale of drugs on the black market.
13. Improper use/request for Dispense-as-Written for a brand drug without trying alternative brand or generic medications under a step therapy process.
14. Theft of a DEA number or prescription pad.
15. Member doctor shopping to obtain excess prescriptions or services.
16. Any other action, which is based on the facts and circumstances, violates the Fraud, Waste, and Abuse (FWA) provisions of the Plan.

Provider Violations Constituting Violation of the FWA Provisions

The following actions, which are not all inclusive, constitute a violation of the Fraud, Waste and Abuse (FWA) Provisions on the part of any provider.

1. Falsification of records, bills, enrollment applications.
2. Duplicate claims submissions or double billing for certain services.
3. Improper Coordination of Benefits information or deliberate suppression of subrogation where there is third party liability for an injury or illness.
4. Marketing schemes such as offering an enrollee a cash incentive to enroll in a program, for example waiving the initial office visit copay for a new patient.
5. Illegal use of free samples, e.g., a physician bills plan/patient for the free samples.
6. Billing for a more expensive item than supplied, e.g., billing for a power wheelchair but supply a scooter to the patient.
7. Unbundling, e.g., billing each test separately for a liver panel.
8. Up coding, e.g., treating an enrollee for the flu but coding it as pneumonia; billing for an extended office visit 30-45 minutes when only a routine/brief office visit of 15 minutes or less was provided; or billing group therapy as individual therapy.
9. Completing Certificates of Medical Necessity (CMN) for patients not personally and professionally known by the provider or supplier.
10. Incorrectly billing for secondary payers to receive increased reimbursement.
11. Billing for non-existent prescriptions or supplies.
12. Billing for non-covered items as covered items.
13. Billing for prescriptions that were never picked up.
14. Inappropriate use of dispense-as-written codes.
15. Drug diversion.
16. Prescription splitting to receive additional dispensing fees.
17. Prescription drug shorting but billing for the full prescribed amount.
18. Bait-and-switch pricing: Member is led to believe the cost will be one price but at point of sale/service the cost is greater.
19. Prescription forging or altering, including theft of a DEA number or prescription pad.
20. Marketing schemes including unsolicited marketing to members at their place of employment or by way of any mass mailing (including emails). This includes the distribution of any marketing material designed to encourage members to avail themselves of your services.

21. Failure to timely bill claims when there is an assignment of benefits on file that would increase the member's responsibility. Providers are required to submit all claims for payment within 90 days of the date of service or 90-days of the date primary benefits are paid and received by the provider. The provider is responsible for any late filing penalties where the provider accepts an assignment of benefits and may not pass this penalty on to the member.

22. Requesting payment in advance for services other than the standard copay or deductible if you are a PPO provider.

23. Balance billing a member for the PPO discount or for any charges that are denied due to violation of the plan's pre-certification requirements or timely claims submission rules. Any PPO provider is to write off such expenses in their entirety and is only entitled to combined provider and member payment up to the actual allowable or negotiated charges.

24. Gouging, inappropriate, or inequitable billing practices by out-of-network providers resulting in charges far greater than would be allowed by major healthcare carriers, including Medicare, Blue Cross/Blue Shield, Aetna, United Health Care and other; and which would be accepted as full payment for the same services rendered by such providers.

    - Excessive pricing of any supply item, generally any mark up in excess of 100% of the actual cost of a supply item as documented by the supplier's invoice may be considered excessive, irrespective of any PPO agreement if the PPO discount is a percentage of savings. A percentage of savings contract does not permit a provider to bill excessive charges to increase their reimbursement/benefit payment under the Plan, by up-charging for supplies.

    - Any provider who is also a Medicare provider is deemed to be billing excessively for services if such services are billed at rate that substantially exceeds what would have been allowed by Medicare as determined by the Plan based on all facts and circumstances, including the average fees accepted for such services in the same geographic area by the majority of the providers.

    - Excessive billing by any provider (in or out-of-network) for any service or item is deemed to be a fraudulent act. <u>For example</u>:

        a. Charging $10 for a single aspirin, Advil, or Tylenol;

        b. Charging $3,000 for premium lens per eye following cataract surgery when the cost of a single premium lens is approximately $900 (more than 300% markup); or

        c. Charging $50,000 for a surgical implant that only cost the hospital $5,000.