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Local 802
Musicians Health Fund
Summary Plan Description

LOCAL 802 AFM

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New York, NY 10036

(212) 245-4802

Plan Revised as of March 2021

Local 802 Musicians Health Fund

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About This Booklet

This booklet is the Summary Plan Description (“SPD”) for the Local 802 Musicians Health Plan. It replaces and supersedes any previous SPD that you received. The primary purpose of this booklet is to help you understand how the Plan works and provide you with a non-technical, summary explanation of the most important features of the Plan. We urge you to read it carefully so that you will understand the Plan as it applies to you and to your family. We also suggest that you share this booklet with your family, and that you keep it in a safe place for future reference. If you lose your copy, please feel free to ask the Local 802 Musicians Health Fund Office for another copy.

This booklet does not change or otherwise interpret other official Plan documents, including the Trust Agreement and collective bargaining agreements establishing the Plan as well as any applicable Certificates of Insurance issued by insurers. Your complete rights are determined by referring to this booklet and all of the other official Plan documents (which are available for your inspection at the Local 802 Musicians Health Fund Office).

Please note that no individuals other than the Board of Trustees of the Plan have any authority to interpret the Plan (including this Summary Plan Description and other official Plan documents), or to make any promises to you about it. In addition, the Plan's Board of Trustees reserves the right, in its sole and absolute discretion, to amend or end this Plan, in whole or in part, at any time and for any reason. No benefits described in this booklet are guaranteed.

Local 802 Musicians Health Fund

April 22, 2021

Dear Musician:

We are pleased to provide you with this new Summary Plan Description ("SPD") that describes the benefits available to you and your eligible Dependents under the Local 802 Musicians Health Fund (the "Fund" or "Plan"). The benefits described in this booklet are the result of the continuous efforts of the Board of Trustees (the "Trustees") to furnish you with a program of benefits that will help meet your needs.

Don't forget that coverage is financed primarily through Employer contributions made on your behalf under the terms of collective bargaining agreements negotiated by Local 802. Because many musicians work for multiple Employers in a year, we ask that you be sure that contributions are being made on your behalf at all your jobs. (See page 00 for more details on eligibility and participation.)

We urge you to read this booklet carefully to familiarize yourself with benefits provided under the Plan. Share it with your family and keep it in a convenient location for future reference.

The Trustees work diligently to maintain high quality benefits; however, it must be recognized that general economic conditions, cessation of Employer contributions and other factors beyond the Trustees' control could affect the financial condition, capabilities and viability of the Fund. Please note that all benefits are subject to the terms of the Trust Agreement and the other official plan documents that establish and govern the Fund's operations.

Sincerely,

Board of Trustees
Local 802 Musicians Health Fund

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For Help or Information

When you need information, please check this document first. If you need further help, call the contacts listed in the following Quick Reference Chart:

Quick Reference Chart
Helpful Information on Plan Administration

If you need Information on:	Please Contact:
General Plan Information and Eligibility • Eligibility • Enrollment • Information about USERRA, FMLA, QMCSOs and your Rights under the Plan • Requesting documents or other Plan related information • General questions about Plan coverage • Contacting the Board of Trustees	Local 802 Musicians Health Fund Office 322 West 48th Street New York, NY 10036 Phone: (212) 245-4802, ext. 171, 172, 173 and 178 Fax (212) 245-2304 https://www.local802afm.org/local-802-healthcare/
COBRA Coverage • Information about COBRA and HIPAA • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments	
HIPAA Privacy Officer/ **HIPAA Security Officer**	
Loss of Time Benefit • Initiate a Claim/Request Payment of Benefits **Sick Pay Benefit** • Initiate a Claim/Request Payment of Benefits **Earplug Benefit** • Initiate a Claim/Request Payment of Benefits **Vision Benefit** (Self-insured Vision Benefit for Plans A and A+) • Provider Directory • Initiate a Claim/Request Payment of Benefits	

If you need Information on:	Please Contact:
Plans A and A+ Aetna Choice POS II **Medical Plan Benefits** • ID Cards/Eligibility for benefits • Medical Network Provider Directory • Additions/Deletions of Providers • Out-of-Network Claims • Plan Benefit Information • Claims questions • First and Second Level Appeals of Medical claims determinations • Coordination of Benefits • Subrogation **Medical Management Program** • Precertification • Case Management	Aetna Choice POS II Medical Plan Benefits P.O. Box 981106 El Paso, TX 79998-1106 Telephone: (800) 370-4526 Member Services # (877) 843-8498
Prescription Drug Benefits • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Formulary of Preferred Drugs • Precertification and Step Therapy • Direct Member Reimbursement (for Non-network retail pharmacy use) • Specialty Drugs (Accredo Pharmacy)	Express Scripts P.O. Box 66773 St. Louis, MO 63166-6773 Member Services: (866) 544-2926 Pharmacist Help Desk: (800) 235-4357 www.express-scripts.com **Mail-Order** Express Scripts, Inc. PO Box 52150 Phoenix, AZ 85072 Accredo Specialty Pharmacy (877) 222-7336 www.accredo.com
Plan B Insured Dental Benefits • Dental Network and Provider Directory • Dental Claims	Delta Dental One Dental Drive Mechanicsburg, PA (717) 766-8500 or toll-free at (800) 932-0783 www.deltadentalins.com
Plan B Insured Vision Benefits • Vision Network and Provider Directory • Vision Claims	Eye Med www.eyemed.com 1-866-804-0982.

Eligibility

Participant's Initial Eligibility

Participating Employers are required to make contributions to the Fund on your behalf if you work for an Employer who is a signatory to a Local 802 AFM collective bargaining agreement (CBA) requiring such contributions. The CBA sets the contribution level for the work you perform for a Participating Employer. Work you perform for a Participating Employer for which contributions are made to the Fund on your behalf is considered "Covered Employment".

If a certain amount of Employer contributions are made on your behalf during a six-month Contribution Period, you will be eligible for health coverage from the Fund during the corresponding six-month Coverage Period. Since you may work for several Employers in a single Contribution Period, the Fund looks at all of the Employer contributions made on your behalf during that period in order to determine whether you are eligible for coverage and for which Plan you are eligible.

In order to be eligible, you must have the following minimum contributions made on your behalf during a six-month Contribution Period (January 1- June 30th or July 1st to December 31st). You will be eligible for one of the Fund's three benefit options based on the amount of contributions that are received on your behalf in accordance with the following:

Minimum Contribution Requirements

Plan A+	$4,500
Plan A	$2,000
Plan B	$500

When you reach the minimum contribution level during a six-month Contribution Period, you and your eligible Dependents are eligible for coverage under one of the above available plans for the corresponding Coverage Period provided you properly enroll and pay the required premium (if applicable) as described below. Once you become eligible, properly enroll in coverage and pay the applicable premiums, you will be considered a Participant in the Plan.

The Coverage Period for each respective Contribution Period is provided below:

For the Contribution Period that runs for the Six-Month Period from:	The Coverage Period will be the Six-Month Period from:
January 1–June 30	September 1–February 28 (or February 29)
July 1–December 31	March 1–August 31

Dual Contributions

If you and your spouse or eligible domestic partner are both active employees working for an Employer contributing to the Fund on your behalf, but neither of you has earned sufficient Employer contributions to establish eligibility, the earned Employer contributions may be combined for the purpose of obtaining family coverage.

However, only one member can be considered the covered Participant; the other person is considered a dependent. You have the option to designate who will be considered the covered Participant. This decision does not have to be based on who has the greater amount of Employer contributions.

Continuing Eligibility

Once covered by the Fund, you will continue to be eligible for coverage during subsequent Coverage Periods provided that sufficient Employer contributions are made on your behalf for the corresponding Contribution Period, as described above.

Excess Contributions (BANK)

If you have contributions over the minimum requirement for coverage for your Plan option (Plan A or Plan A+ only), the excess amount can be carried forward from the previous two six-month Contribution Periods to maintain continued eligibility. For each Contribution Period, your "account" will be charged with the amount of contributions required for eligibility and the excess, if applicable, will be carried forward and applied to the next Contribution Period. The maximum amount of credit that may be carried forward is equal to the total amount of the contributions required for the previous 12-month period.

Level of Benefits

The level of Employer contributions made to the Fund on your behalf will determine your level of benefits.

- Plans A and A+ are comprehensive medical benefits administered by Aetna on a self-insured basis. In addition, vision, earplug and prescription drug coverage is provided on a self-insured basis for Participants in Plans A+ and A.
- Plan B offers fully-insured dental and vision plans and the self-insured earplug benefit. Plan A or Plan A+ Participants may also “buy-up” to the Plan B fully-insured dental and vision benefits by paying the six month premium in advance.

Plan	Minimum Contribution Requirements	Benefits
Plan A+	$4,500	Comprehensive Medical (A+), Prescription Drug, Vision, Ear Plug (Plan B Dental and Vision buy-up also available)
Plan A	$2,000	Comprehensive Medical (A), Prescription Drug, Vision, Ear Plug (Plan B Dental and Vision buy-up also available)
Plan B	$500	Fully-insured Dental and Vision Benefits

Participant Premiums

Participants are required to pay a quarterly premium for coverage under Plans A and A+ and may “buy-up” to the more robust Plan B dental and vision benefits for an additional premium for the

entire six month coverage period. If a Participant gains eligibility for Plans A or A+ and does not pay the required premium, the Participant will automatically receive Plan B benefits at no cost. Participants are not required to contribute toward the cost of their own coverage under Plan B.

Required Participant premiums are detailed below.

Quarterly Participant Premiums

Plan Level	Premium
Plan A+ ($4,500 level of Employer contribution)	$300 Individual $1,200 Family
Plan A ($2,000 level of Employer contributions)	$300 Individual $1,200 Family
Plan B ($500 level of Employer contributions)	None
Plan B Dental and Vision "Buy-up" for Plan A and A+ Participants (six-month premium paid in advance)	$247 Individual $692 Family

If you are required to make a premium payment, you will receive an invoice from the Fund. The invoice will state when the payment is due and when the 30-day premium payment grace period expires. **Payments MUST be postmarked at latest by the last day of the grace period in order to be considered timely.**

Dependent Eligibility

Once you become eligible for coverage, your eligible Dependents are also eligible for health care coverage from the Fund. Coverage for your existing eligible Dependents becomes effective on the same day as your coverage, provided you enroll them, provide proof of dependency, and pay the required premium. Your eligible Dependents include your:

- Lawful spouse to whom you are legally married (determined in accordance with applicable State law);
- Domestic Partner (who meets the Plan's eligibility requirements);
- Eligible children up to age 26. Coverage is available for children up to the end of the calendar year in which the child reaches age 26 regardless of whether the child is married or unmarried, and regardless of the child's student status, employment status, financial dependency on you, or any other factor other than the relationship between you and your child.

  For the purposes of the Plan, your "children" include:

  - Your biological child(ren)
  - Your legally adopted child(ren)
  - Child(ren) placed with you for adoption. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt
  - Your domestic partner's child(ren)
  - Your step child(ren)

- Your foster child(ren) who has been lawfully placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction for whom health coverage is not provided by the state
- Child(ren) for whom you are responsible under court order or appointed legal guardianship
- Child(ren) for whom you are responsible to provide medical coverage as a result of a Qualified Medical Child Support Order (QMCSO)
- Disabled Dependent child(ren) over age 26 who meet all of the following requirements:
    - is unmarried:
    - has been continuously covered under the Plan prior to attainment of the age 26 and was covered under this Plan on the day before their 26th birthday;
    - is disabled prior to attainment of age 26 and that disability causes the individual to be incapable of self-sustaining employment (substantial gainful employment),
    - chiefly dependent on the Participant for support and maintenance; and
    - who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively OR and who will be claimed as a dependent on the employee's/Participant's federal income tax return for each plan year for which coverage is provided. To be eligible for tax-free health coverage as a "qualifying child," an unmarried child with a permanent and total disability must have the same principal place of abode as the Participant for more than half of the year and must not provide over half of his/her own support for the year. To be eligible for tax-free health coverage as a "qualifying relative," the Participant must provide over half of the child's support, and the child must not be the "qualifying child" of any person.

Dual Coverage

If you are eligible as a covered Participant and also as a covered Dependent under this Plan because your spouse or Domestic Partner is a covered Participant, benefits will be payable to you as a covered Participant and then as a Dependent on a secondary basis. Each covered person may claim benefits on behalf of his or her dependent children up to the maximum amounts provided under this Plan. However, in no event will the aggregate of benefits payable exceed 100% of the actual Covered Medical Expenses incurred.

Domestic Partners

The Plan offers coverage for Participants' Domestic Partners. For purposes of the Plan, a Domestic Partner is defined as two individuals who:

- are at least 18 years of age or older;
- are of the same or opposite sex;
- are not married to, or legally separated from, another individual, and are not in a domestic partner relationship with any other individual;
- are not related by blood to a degree of closeness that would prohibit marriage in their state of residence;

- have lived together in the same residence for at least six months prior to the application for benefits and presently intend to live together indefinitely; and are financially interdependent, which must be demonstrated by the types of evidence described in the Fund's Policy regarding Domestic Partner Benefits.

Enrollment

Initial Enrollment

The Fund Office determines Participant eligibility based on Employer contributions remitted during the applicable eligibility period and calculates whether you are eligible for each Coverage Period. When you meet the eligibility requirements for a particular Coverage Period, the Fund Office will notify you and send you enrollment materials. You must complete an enrollment form for each Coverage Period (even if you have previously enrolled) to ensure that the Fund Office has the proper information for you. Coverage will only be effective when the Fund Office receives the completed enrollment forms and **you pay the applicable Participant contribution by the due date.**

If you wish to enroll your Dependents, you must complete the required enrollment form and return it to the Fund Office with the appropriate supporting documentation (as described below) no later than 30 days after the start of the Coverage Period as well as **pay the applicable Participant contribution by the deadline** described in the enrollment materials**.**

> **IMPORTANT NOTE:** As noted above, in order for you and your eligible dependents to be covered under the Plan you need to enroll them and pay the applicable Participant premium in a timely manner.

If you do not enroll your dependents within the first 30 days of the Coverage Period, you will not be able to enroll them for the current Coverage Period. You will have to wait until the next Coverage Period (or a Special Enrollment event, if earlier) in order to enroll them.

Proof of Dependent Status

If you wish to enroll your dependent(s), a copy of the following proof is required:

- **Spouse/Marriage:** the certified marriage certificate;
- **Child/Birth:** the certified birth certificate showing biological child of Participant;
- **Stepchild:** the certified birth certificate showing spouse as parent of child, divorce decree (if applicable) and marriage certificate between Participant and child's parent;
- **Adopted child or child placed for adoption**: court order paper signed by the judge showing that employee has adopted or intends to adopt the child and birth certificate;
- **Foster child**: documentation showing the child has been legally placed as a foster child with the Participant and birth certificate;
- **Disabled Dependent Child:** Current written statement from the child's Physician indicating: the child's diagnoses that are the basis for the Physician's assessment that the child is currently disabled; that the disability existed before the attainment of the Plan's age limit; and that the child is incapable of self-sustaining employment as a result of that disability. You must also provide proof that the Child is chiefly dependent on you and/or your Spouse for support and maintenance (proof that the child is claimed as a dependent for federal

income tax purposes). The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child.

- **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document signed by a judge or a National Medical Support Notice.
- **Domestic Partner**: Signed and notarized affidavit by the employee and domestic partner that they meet the requirements of this Plan's domestic partner eligibility using the Plan's "Statement of Domestic Partnership" form, and any state recognized Domestic Partner registration form.

Domestic Partner Coverage, Enrollment and Important Tax Consequences

Domestic Partners (and their eligible children) are eligible for health coverage on the same basis as spousal (and dependent child) coverage is provided under the Fund. Enrollment of a Domestic Partner (and child) must occur at one of the following times:

- when the Participant first becomes enrolled in the Fund for him/herself,
- during the Fund's annual enrollment period,
- within 30 days of entering into a civil union,
- within 30 days of the birth or adoption of a child of the Domestic Partner (provided that the Domestic Partner is enrolled for coverage either before or at that time), or
- within 30 days of the individual's loss of other coverage, provided that sufficient proof of loss is provided to the Fund Office.

Coverage will be effective in accordance with the Fund's enrollment rules.

Please note that the Internal Revenue Service ("IRS") generally does not recognize domestic partners or civil union partners (or their children) as eligible dependents under the Internal Revenue Code's provisions regarding Employer-sponsored health plans. Therefore, unless the Domestic Partner (or child) is the Participant's "dependent" as defined in Section 105(b) of the Internal Revenue Code, the fair market value of the health coverage provided by the Fund to the Domestic Partner and his or her children will be included in the Participant's gross income, subject to Federal income tax withholding and employment taxes, and will be reported by the Fund on an IRS Form W-2. The value of the coverage may also be subject to State and City income tax depending on the applicable state and locality.

A Participant who enrolls a Domestic Partner (and his or her child) for coverage under the Fund will receive an IRS Form W-2 reflecting the value of the coverage provided by the Fund (as determined in the Fund's discretion, and as may be changed from time to time without prior notice). The Fund generally calculates the fair market value of Domestic Partner coverage using the applicable COBRA rate (not including the 2% administrative fee).

If a Participant believes that his or her Domestic Partner or his/her child qualifies as the Participant's dependent under the Internal Revenue Code, the Participant must submit a notarized certification to the Fund Office. In general, in order to qualify as the Participant's dependent for this purpose, the individual: (i) must be a member of the Participant's household during the entire taxable year, and (ii) must receive more than half of his or her support from the Participant. Participants are strongly encouraged to consult with a tax advisor regarding all of the requirements for dependent status before completing such a certification.

Important Note Regarding Penalties for Providing Incorrect or Incomplete Information: If the Fund (or its designee) determines that a Fund Participant or Domestic Partner has committed fraud or made an intentional misrepresentation of a material fact (including, for example, in the Affidavit or enrollment forms; in a benefit claim or appeal; in response to any request for information by the Fund (or its designee); or has failed to timely notify the Fund of a divorce, the termination of a Domestic Partnership or the dissolution of a civil union within 30 days of such termination, divorce or dissolution, coverage may be terminated retroactively on thirty (30) days written notice. Coverage may also be terminated retroactively and without notice (unless required by law) if the Fund (or its designee) determines that the Domestic Partner or child is ineligible for coverage under the Plan and such retroactive termination would not be considered a "rescission" under applicable federal law.

If coverage is terminated retroactively, the Participant will be required to reimburse the Fund, its insurers and agents for any expenditures made by them for benefit claims, processing fees, administrative charges and all other costs (including interest and any attorneys' fees incurred in order to collect such amounts) on behalf of a Dependent or Domestic Partner and his or her child. In addition, the Participant may be subject to further action (such as termination of coverage) in the discretion of the Board of Trustees.

Special Enrollment Rights

If you do not enroll for coverage or decline enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 30 days after your coverage or your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You and your dependents may also enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.

You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, please contact Ms. Gloria McCormick, the Fund Administrator, at the Fund Office, 322 West 48th Street, New York, New York 10036, or by phone at (212) 245-4802.

Effective Date of Coverage Following Special Enrollment

For newly added dependents, if the Fund Office receives a completed request for enrollment within thirty (30) days of the date of the marriage, birth, adoption, placement for adoption, or

loss of other group coverage, coverage will be effective as follows, provided the required Participant premium is timely paid:

- For newborn child(ren): Newborn child(ren) are entitled to benefits from the date of birth.
- For adopted child(ren): Adopted child(ren) are covered from the date that child is adopted or "placed for adoption" with you, whichever is earlier. "Placed for adoption" means the lawful placement of the child for legal adoption, and the assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption. A child who is placed for adoption with you within thirty (30) days after the child was born will be covered from birth. However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.
- For your new spouse: Your new spouse is covered retroactive to the date of your marriage.
- Following loss of other group coverage: Your dependent(s) will be covered retroactive to date of loss of other coverage.
- Following loss of coverage under or eligibility for Medicaid/CHIP

Late Enrollment: If your enrollment is received after thirty (30) days (or 60 days if eligible for a Medicaid/CHIP enrollment right), coverage will begin as of the next Coverage Period.

If you are enrolled in any insured benefits such as the Plan B dental and vision, there may be some variations in how new dependents are covered due to state insurance laws. Please see the eligibility and enrollment sections in the applicable Certificate of Insurance for information on how these provisions are applied.

When Coverage Ends

Your coverage under the Plan ends on the earliest of any of the following events:

- The end of the Coverage Period following the Contribution Period in which there are insufficient contributions credited on your behalf to qualify for any benefit option provided by the Fund.
- The last day of the period for which you have last timely paid the required premium amounts, if any;
- The date the Plan terminates;
- The date you die.

When your coverage ends, you may have the right to continue coverage under the Fund for a temporary period on a self-pay basis pursuant to COBRA and/or State law, depending on the reason for which coverage ends. See pages 23 through 33 for information regarding continuation coverage.

When Dependent Coverage Ends

Under this Plan, Dependent coverage will end upon the earliest of the following dates:

- The date that your (the Participant's) coverage ends for any reason (including the Participant's death);
- The date the Dependent no longer meets the Plan's definition of Dependent which include:
  - For a spouse and stepchildren, date of divorce;
  - For children, earlier of: end of year child reaches age 26; the date a disabled child no longer meets all the requirements to be covered; or the date of dissolution of placement of child as foster child.
- The date the Plan is amended to terminate coverage for Dependents; or
- The date this Plan terminates.

When a Dependent's coverage ends, he/she may have the right to continue coverage under the Fund for a temporary period on a self-pay basis pursuant to COBRA, depending on the reason for which coverage ends. See pages 23 through 33 for information regarding continuation coverage.

When Domestic Partner Coverage Ends

Coverage extended to a Domestic Partner and his/her eligible children will end on the earliest to occur of the following:

- The date that the Participant's coverage under the Fund ends for any reason (including the Participant's death);
- The date the Plan is amended to terminate coverage for Domestic Partners and their children;
- The date the Dependent no longer meets the Plan's definition of Dependent;

- The date the Participant voluntarily dis-enrolls the Domestic Partner and child(ren) from coverage at any time, by providing written notice to the Fund Office; or
- The date the partners no longer satisfy the requirements of a Domestic Partnership as described herein (or, in the case of a marriage or civil union, when the parties have divorced or dissolved their civil union), in which case coverage will end on the last day of the month in which the parties no longer satisfy the requirements for a Domestic Partnership, or on the date of the divorce or dissolution of their civil union.

  You must notify the Fund Office in writing within 30 days of the date that the parties no longer satisfy the requirements of a Domestic Partnership (or within 30 days of a divorce or dissolution of a civil union, in those cases). In cases of divorce or dissolution of a civil union, the Participant must provide the Fund Office with a copy of divorce decree or dissolution certificate within 30 days of the divorce or dissolution.

Important Note: Upon termination of coverage, a Domestic Partner and his/her children will only be entitled to federal COBRA continuation coverage *if the Participant is eligible for and receiving COBRA coverage for him/herself.* A Participant may not enroll a *new* Domestic Partner for coverage under the Fund within twelve (12) months of the termination of another Domestic Partner's coverage, except in cases of a new marriage or civil union.

Rescission of Benefit

No benefits are payable on a claim if the person who files the claim or for whom the benefit is claimed, or if the provider of the service that is subject of the claim, attempts to perpetrate a fraud upon or misrepresent a fact to the Plan with respect to that claim. Failure to provide complete, updated and accurate information to the Fund Office on a timely basis regarding your marital status, employment status of a spouse or child, or the existence of other coverage constitutes intentional misrepresentation of a material fact to the Plan.

Coverage for you (the Participant) and/or your Dependents may be terminated retroactively (rescinded):

- In cases of fraud or intentional misrepresentation (in such cases, you will be provided with 30-day notice);
- Due to non-payment of premiums (including COBRA premiums).

If coverage is terminated, you may be required to repay to the Fund amounts incorrectly paid by the Fund. The Board of Trustees may commence legal action against a Participant or other individual for restitution and hold them liable for all costs of collection, including interest and attorneys' fees. The Board of Trustees may also offset future claim payments with respect to the Participant or dependent to recover amounts owed.

COBRA Continuation of Coverage

IMPORTANT

This section serves as a notice to summarize your rights and obligations under the COBRA Continuation Coverage law. It is provided to all covered employees and their covered Spouses and is intended to inform them (and their covered dependents, if any) in a summary fashion about COBRA coverage, when it may become available and what needs to be done to protect the right to receive COBRA coverage. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your Spouse take the time to read this section carefully and be familiar with its contents.

Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly called COBRA), eligible employees, and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law). Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

COBRA Administrator: The name, address and telephone number of the Plan Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is the Fund Office. See the Quick Reference Guide at the beginning of this document for contact information.

Other Health Coverage Alternatives to COBRA

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

Enrolling in Marketplace Coverage

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

COVERAGE THROUGH THE MARKETPLACE MAY COST LESS THAN COBRA CONTINUATION COVERAGE. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days, your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

You should keep in mind that if you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." Be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage once your election period ends.

Enrolling in another group health plan

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage. If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

Enrolling in Medicare instead of COBRA continuation coverage after coverage ends

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage when a Qualifying Event occurs, and as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

"Qualified Beneficiary": Under the law, a Qualified Beneficiary is any Participant or the Spouse or Dependent Child of an employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

- A child of the covered employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
- A person who becomes the new Spouse of an existing COBRA Participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA Participant but is not a "Qualified Beneficiary." This means that if the existing COBRA Participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.
- Domestic partner

  Important Note: Upon termination of coverage, a Domestic Partner and his/her children who are not Dependents of the Participant will only be entitled to federal COBRA continuation coverage *if the Participant is eligible for and receiving COBRA coverage for him/herself.*

"Qualifying Event:" Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, and, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan. If a covered individual has a Qualifying Event but, as a result, does not lose their health care coverage under this Plan, (*e.g.* employee continues working even though entitled to Medicare) then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

	Duration of COBRA		
Qualifying Event Causing Health Care Coverage to End	**Employee**	**Spouse**	**Dependent Child(ren)**
Employee terminates (for other than gross misconduct), including retirement.	18 months	18 months	18 months
Employee reduction in contributions (making employee ineligible for the health care coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the loss of Plan coverage. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in another section of this chapter on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears later in this chapter.

Special Enrollment Rights

You have special enrollment rights under federal law that allow you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's Employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Procedure for Notifying the Plan of a Qualifying Event

In order to have the chance to elect COBRA Continuation Coverage after loss of coverage due to these events: a divorce or legal separation, or a child ceasing to be a "dependent child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that Qualifying Event occurs.**

That written notice should be sent to the Plan Administrator. The written notice can be sent via first class mail, hand-delivered or via email, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE: If such a notice is not received by the Fund Office within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Notices Related to COBRA Continuation Coverage

The Plan Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

The COBRA Continuation Coverage That Will Be Provided

COBRA Continuation Coverage entitles a person to the same health coverage that they had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

Paying for COBRA Continuation Coverage

Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated active employees and families plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

IMPORTANT

There may not be invoices or payment reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the Plan Administrator.

Grace Periods

The **initial payment** for the COBRA Continuation Coverage is due to the Plan Administrator **no later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect.

After the initial COBRA payment, **subsequent payments** are due on the first day of each month, but there will be **a 30-day grace period** to make those payments. If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. Payment by mail is considered made when it is postmarked.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent by the Plan Administrator an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced, legally separated, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected dependent is extended to 36 months measured from the date of the initial qualifying event.

Notifying the Plan: To extend COBRA when a second Qualifying Event occurs, you must notify the Plan Administrator in writing within 60 days of the second Qualifying Event. The written notice can be sent via first class mail, be hand-delivered or sent via email, and is to include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.

This extended period of COBRA Continuation Coverage is *not* available to anyone who became your Spouse after the termination of employment or reduction in hours.

This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage.

In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event and COBRA may not be extended beyond 18 months from the initial Qualifying Event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Extended COBRA Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

If, prior to the Qualifying Event or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent Child are totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose, may be entitled to keep the COBRA Continuation

Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

This extension is available only if the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and t**he disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

Notifying the Plan: You or another family member must send a written notification to the Plan Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the Plan Administrator before the end of the 18-month COBRA Continuation period.

1. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage may be up to 50% higher than the cost for coverage during the first 18-month period.
2. The Plan Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date the premium payment amount due for COBRA coverage is not paid in full and on time;
2. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
3. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan

   IMPORTANT: The Qualified Beneficiary must notify the Fund Office as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Plan ends on the date the Qualified Beneficiary is covered under the other group health plan.
4. During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled;
5. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA Participants under the Plan).
6. The date the Employer Fund no longer provides group health coverage to any of its employees.

Notice of Early Termination of COBRA Continuation Coverage

The Plan Administrator will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the Plan Administrator determines that COBRA coverage will terminate early.

Once COBRA coverage terminates early it cannot be reinstated.

COBRA Questions or To Give Notice of Changes in Your Circumstances

If you have any questions about your COBRA rights, please contact the Plan Administrator. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit their website at www.dol.gov/ebsa. The addresses and phone numbers of Regional and District EBSA offices are available through this website.

Remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the Plan Administrator:

1. within 31 days of a change in marital status (e.g. marry, divorce); or have a new dependent child; or
2. within 60 days of the date you or a covered dependent Spouse or child has been determined to be totally and permanently disabled by the Social Security Administration; or
3. within 60 days if a covered child ceases to be a "dependent child" as that term is defined by the Plan; or
4. promptly if an individual has changed their address, becomes entitled to Medicare, or is no longer disabled.

New York State Continuation Assistance Demonstration Program for Entertainment Industry Employees

You may be eligible for assistance with COBRA premiums if the New York State Insurance Department determines that you are eligible for the New York State Continuation Assistance Demonstration Program for Entertainment Industry Employees. There are specific eligibility requirements including an income limitation that will be used to determine eligibility.

Family and/or Medical Leave

The Family Medical Leave Act, 29 USC §2601 et seq. provides that if you work for an employer covered by that Act you are entitled to unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care for a spouse, child or parent who is seriously ill, for your own illness, or to care for family members who have served in the military. In general, the employers covered by FMLA are those who employ 50 or more employees for each working day during each of 20 or more calendar weeks in the current or preceding calendar

year. If you are taking FMLA leave that has been approved by your employer, your employer is responsible for notifying the Plan and making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your Employer.

Of course, any changes in this Plan's terms, rules or practices that go into effect while you are away on leave will apply to you and your dependents, the same as to active employees and their dependents. If you do not return to covered employment after your leave ends, you are entitled to COBRA Continuation Coverage when your leave ends.

Call your employer to determine whether you are eligible for FMLA leave. Then call the Fund Office to learn more about your coverage during FMLA leave.

New York Paid Family Leave (or other Paid State Leave Requiring Continuation of Coverage)

You are also entitled to continue your health coverage while on a New York Paid Family Leave (PFL) (or other similar paid state leave) as required by the law. During the PFL, you will maintain the coverage you were eligible for at the time you started PFL until the end of your leave, as long as your Employer properly grants the leave under New York PFL (or other comparable state leave) and makes the required notifications and contributions to the Fund Office on your behalf.

Continued Coverage During Military Leave

A Participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA? USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

An employee's coverage under this Plan will terminate when the employee enters active duty in the uniformed services.

- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage on a self-pay basis for up to 24 months measured from the date the employee stopped working.
- If the employee goes into active military service for **up to 31 days**, the employee (and any eligible dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the employee continues to pay the appropriate contributions for that coverage during the period of that leave.

Duty to Notify the Plan: The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been

called to active duty in the uniformed services and provides a copy of the orders. The employee must notify the Plan Administrator as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Plan Offers Continuation Coverage: Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA; therefore, either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA.

Paying for USERRA Coverage:

- If the employee goes into active military service for up to **31 days**, employees are required to pay only the same amount for continuation coverage as they were paying for active coverage.
- If the employee elects USERRA temporary continuation coverage, the employee (and any eligible dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the date the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage. See the COBRA chapter for more details.

USERRA allows the employee to apply accumulated eligibility toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. When your accumulated eligibility is exhausted, you may pay for USERRA coverage under the self-pay rules of this Plan. If you do not want to use your accumulated eligibility to pay for USERRA coverage, you can choose to freeze your eligibility and instead proceed to pay for the USERRA coverage under the self-pay rules of this Plan. You should contact the Fund Office to discuss the effects of this choice when you first go into military service.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

USERRA allows the employee to apply hours in their accumulated eligibility or hours bank toward the cost of continuation coverage in lieu of paying for the USERRA continuation coverage. When an employee's accumulated eligibility hour bank is exhausted, the employee may pay for USERRA coverage under the self-pay rules of this Plan. If the employee does not want to use their hour bank to pay for USERRA coverage, the employee can choose to freeze the hour bank and instead proceed to pay for the USERRA coverage under the self-pay rules of this Plan.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the Fund Office.

Aetna Choice POS II Plan Medical Benefits

If you are eligible for Plan A+ or Plan A, you are eligible for comprehensive medical and benefits administered under a self-insured contract with Aetna. Generally speaking, the services covered under either Plan A or Plan A+ are the same. The difference between the two plans is the level of coverage and cost-sharing; the portion of the cost you pay out of your own pocket is greater under Plan A than under Plan A+. This section describes the coverage under the Plan A and Plan A+ Plan options. The Pan A+ and Plan A *Schedules of Benefits* that begin on page 41 and page 49 respectively outline the cost-sharing applicable to each Plan.

How this Plan Works

The Fund provides you with comprehensive medical benefits through the Aetna Choice POS II Network. These plans provide coverage for Medically Necessary eligible health services from either in-network or out-of-network providers. You may obtain health care services from in-network or out-of-network providers, but your out-of-pocket expenses differ depending on whether you use in-network or out-of-network providers. There are different cost-sharing provisions for in-network and out-of-network providers that are described in general in this section and outlined in the *Schedule of Benefits*.

In-Network Providers

If you receive covered services or supplies from a provider that is contracted with Aetna through the Choice POS II Network (i.e. are in-network), you will typically pay less money out of your pocket. This means that the portion of expenses that you are expected to pay (e.g., cost-sharing that includes Deductibles, copayments, and coinsurance) will generally be lower when you use in-network providers and facilities. The Plan reimburses eligible health services up to the Negotiated Rate for in-network services. The Negotiated Rate for in-network providers are generally based on rates established in an agreement between the provider and Aetna. Under these agreements, the provider will accept the Negotiated Amount as payment in full so you will not be responsible for any additional expenses beyond the applicable cost-sharing.

While it is generally less expensive to both the Plan and to you to use an in-network provider, the choice is generally yours as to what type of provider to use.

Important Note: Network providers have contracted with Aetna, an affiliate or third party vendor to provide health care services and supplies to Aetna plan members. Network providers are generally identified in the printed directory and the on-line version of the directory via Provider Search Tool at www.aetna.com unless otherwise noted in this section. Out-of-network providers are not listed in the Aetna directory.

Physicians and other health care Providers who participate in the Aetna Choice POS II Network are added and deleted during the year. At any time, you can find out if any provider is In-Network by visiting Provider Search Tool at www.aetna.com or by calling 1-877-843-8498. Because Providers are added or deleted during the year you should call Aetna or ask the provider to verify their contracted network status before your visit.

Looking for an in-network Aetna provider?
You can log onto their website at www.aetna.com, or you can call 1-877-843-8498.

Out-of-Network Providers

If you receive covered services or supplies from providers who are not part of the Aetna network, you will typically pay more money out of your pocket than if you use an in-network provider. This means that the portion of expenses that you are expected to pay (e.g., cost-sharing that includes your Deductibles, copayments, and coinsurance percentage) will generally be higher when you use out-of-network providers and facilities. In addition, you will have to pay the entire amount due for services at the time that they are provided and submit a claim for reimbursement. It is also your responsibility to start the precertification process with providers.

For out-of-network expenses, the Plan reimburses eligible health services up to the Recognized Charge. See the definition of Recognized Charge on page 152 for details on how this amount is calculated. Out-of-network providers are generally free to set their own charges for the services or supplies that they provide, and are allowed to bill you for charges in excess of what Aetna determines to be the Recognized Charge. This is known as "balance billing" and the Plan is not responsible for any balance bills. As a result, when you use an out-of-network provider, you are responsible for any applicable cost-sharing and any charges that the out-of-network provider may balance bill you. This amount could be considerable.

Cost Estimator

Aetna has online tools to help decide whether to get care and if so, where. Use the "Estimate the Cost of Care" tool on Aetna member website. Aetna's secure member website at www.aetna.com may contain additional information that can help you determine the cost of a service or supply. Log on to Aetna member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

Choice of Provider

The Plan does not require but does allow the designation of a primary care provider and you have the right to designate any primary care provider who participates in the Aetna network and who is available to accept you or your family members. You may designate a pediatrician as the primary care provider for your child. In addition, you do not need pre-certification from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a primary care provider, and for a list of the participating primary care providers, pediatricians or obstetrics/gynecology, contact Aetna at the number on your ID card.

Non-Emergency Care Received When Travelling Outside of the United States

If you or your Dependent are traveling outside of the United States, or attending school outside of the United States, then only emergency care will be covered by the Fund. Please see page 146 for the definition of emergency care.

Eligible Health Services and Cost-Sharing

Eligible health services

Eligible health services are those health care services that meet the following requirements:

- They are specifically described in the *Schedule of Benefits* and listed in the *Eligible Health Services* section.
- They are not excluded as described in the *Exclusions: What the Plan Does Not Pay* section.
- They are not in excess of any specific Plan limits as described in the *Schedule of Benefits*.
- The eligible health service is medically necessary.
- You receive the eligible health service from a provider who is properly licensed to provide the services.
- You or your provider precertifies the eligible health service when required.

You will pay the entire expense for services or supplies:

- When you get a health care service or supply that is not Medically Necessary**.**
- When your plan requires precertification, your physician requested it, Aetna refused it, and you receive the service or supply anyway without precertification.
- For cancelled or missed appointments.
- Which are not specifically described in the *Schedule of Benefits* or listed in the *Eligible Health Services* section.
- Which are excluded, as described in the *Exclusions: What the Plan Does Not Pay* section.

In all these cases, the provider may require that you pay the entire charge and any amount you pay will not count towards your Deductible or towards the out-of-pocket limit.

Neither you nor the Plan are responsible for:

- Charges for which you have no legal obligation to pay;
- Charges that would not be made if you did not have coverage; or
- Charges, expenses, or costs in excess of the Negotiated Charge for in-network providers. (You will, however, be responsible for any balances over the Recognized Charge for out-of-network providers; see the *Definitions* section for details on how this amount is calculated).

Participant Cost-Sharing

For most eligible health services, you pay a portion of the Negotiated Rate (for in-network providers) or Recognized Charges (for out-of-network providers) in the form of a "Deductible", "copayment or copay" or "coinsurance". Collectively, these provisions are called "cost-sharing". There are different cost-sharing provisions for Plan A+ and Plan A benefits. Cost-sharing provisions also differ depending on what type of provider you use and the type of eligible health services, and are described in detail in the *Schedule of Benefits*.

Annual Deductible

The Deductible is the amount each individual or family must pay for eligible health services before the Fund pays benefits for certain services.

- For Plan A+, there is no annual Deductible for in-network providers and $1,500/ individual and $3,750/family for out-of-network providers.
- For Plan A, the annual Deductible is $250/individual and $500/family for in-network providers and $2,500/individual and $6,250/family for out-of-network providers.

Any expenses incurred in the last three months of a calendar year that are used to satisfy the Deductible, in part or in full, will also be applied to reduce the Deductible for the following calendar year. Please note that expenses for charges in excess of the Recognized Charge, excluded services, copayments, prescription drug, dental and vision expenses do not count towards the annual Deductible.

Copayments

A copayment (or copay) is a set dollar amount you are responsible for paying when you incur a covered service. Specific copayment amounts are listed in the *Schedule of Benefits* and generally apply only to in-network services, except for emergency room visits.

Coinsurance

Coinsurance is the percentage the Plan pays for eligible health services and varies between the type of service and whether it is in-network or out-of-network. The applicable coinsurance amounts are outlined in the *Schedule of Benefits*.

Example: You are enrolled in Plan A+ and are admitted to a network hospital for a ten-day period. The total network recognized charge is $35,000. You have no Deductible to satisfy and are responsible for 20% of the recognized charge, up to your individual out-of-pocket maximum. This means you pay 20% of the first $25,250 (for a total of $5,050), and the Fund pays the remaining $29,950.

In-Network Out-of-Pocket Maximum

To limit the amount you spend out of your pocket for in-network medical benefits each year, a calendar year in-network out-of-pocket maximum of $5,050 per individual / $10,100 per family will apply for both Plan A+ and Plan A. This means that the Fund will pay 100% of covered in-network medical expenses if you or your family reaches the in-network out-of-pocket maximum.

Your payments for covered in-network medical services, such as copayments, coinsurance and Deductibles, will count towards the calendar year out-of-pocket maximum. In addition, copayments for using out-of-network emergency services will count towards the in-network, out-of-pocket maximum. However, any balance bills associated with the use of out-of-network emergency services that you are responsible for will not count towards the in-network out-of-pocket maximum.

Expenses that do not count towards the in-network out-of-pocket maximum also include prescription drug, optical and dental expenses, excluded services, penalties for not obtaining precertification, and expenses arising from the use of an out-of-network provider. There is a separate out-of-pocket maximum for prescription drugs. Please refer to that section for details.

Precertification

Both Plan A and Plan A+ require precertification for certain services and procedures as described in this section. Precertification is a process that helps you and your physician determine whether the services being recommended are covered expenses under the Plan. It also allows Aetna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

In-network

Your physician is responsible for obtaining any necessary precertification before you get the care. If your physician does not get a required precertification, Aetna will not pay the provider who gives you the care. You will not have to pay either if your physician fails to ask us for precertification. If your physician requests precertification and Aetna refuse it, you can still get the care but the Plan will not pay for it.

Out-of-network

When you go to an out-of-network provider, it is your responsibility to obtain precertification from Aetna for any services and supplies on the precertification list. If you do not precertify, your benefits may be reduced or the Plan may not pay any benefits if, upon retrospective review, Aetna does not consider the expenses to be covered under the Plan. Refer to your *Schedule of Benefits* for this information. The list of services and supplies requiring precertification can be found on the next page.

The Precertification Process

Precertification should be obtained within the timeframes specified below. For emergency services in an Emergency Room, precertification is not required, but you should notify Aetna within the timeframes listed below if you are admitted. To obtain precertification, call us at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
For an emergency admission	Emergency room visits are not subject to prior authorization requirements. However, you, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury.
For outpatient non-emergency medical services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you and your physician of the precertification decision. If your precertified expenses are approved, the approval is effective for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, Aetna will notify you, your physician and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days will need to be certified. You, your physician, or the facility will need to call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If precertification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how Aetna's decision can be appealed. You or your provider may request a review of the precertification decision pursuant to the *Claims and Appeals* section which begins on page 105.

Services and Supplies Which Require Precertification

Precertification is required for the following types of medical expenses:

- Inpatient services and supplies
- Outpatient services and supplies
- Stays in a hospital
- Cosmetic and reconstructive surgery
- Stays in a skilled nursing facility
- Non-emergency transportation by fixed wing airplane
- Stays in a rehabilitation facility
- Transcranial magnetic stimulation (TMS)
- Stays in a hospice facility
- Applied behavior analysis
- Stays in a residential treatment facility for treatment of mental disorders and substance abuse
- Partial hospitalization treatment
- Bariatric surgery (obesity)

How Failure to Precertify Affects Your Benefits

You are responsible for obtaining the necessary precertification from Aetna prior to receiving services from an out-of-network provider. Your provider may request precertification for you; however, you should verify with Aetna prior to the procedure, that the provider has obtained precertification from Aetna. If your treatment is not precertified, Aetna will perform a retrospective review after the claim is incurred and determine whether and what expenses will be covered. If some or all of the expenses are not considered covered expenses by Aetna, the benefit payable may be significantly reduced or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

How Your Benefits are Affected

The chart below illustrates the effect on your benefits if necessary precertification is not obtained.

If precertification is:	then the expenses are:
• requested and approved by Aetna.	covered.
• requested and denied.	not covered, may be appealed.
• not requested, but would have been covered if requested.	covered
• not requested, would not have been covered if requested.	not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because expenses are not considered covered expenses will not count toward your Deductible or annual out-of-pocket limit.

PLAN A+: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
Deductible (per calendar year) • Unless otherwise indicated, the Deductible must be met prior to benefits being payable. • Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. • The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount	None Individual None Family	$1,500 Individual $3,750 Family
Payment Limit (per calendar year) • All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. • Only those out-of-pocket expenses resulting from the application of coinsurance percentage or copay (except any penalty amounts) may be used to satisfy the Payment Limit. • The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.	$5,050 Individual $10,100 Family	Not Applicable Not Applicable

PLAN A+: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
PREVENTIVE CARE AND WELLNESS: Visit maximums only apply to Preventive Care and Wellness benefits that are payable in full In-Network as required by law to be covered as Preventive Benefits. Other Medically Necessary visits, services or supplies will be covered according to the type of benefit and the place where the service is received.		
Routine Physical Exams		
Performed at a physician's, PCP office	Covered at 100% of Negotiated Charge	Covered at 100% of Recognized Charges; Deductible waived
Covered Persons through age 21 Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Covered at 100% of Negotiated Charge	Covered at 100% of Recognized Charges; Deductible waived
Covered persons age 22 and over Maximum one (1) visit per Calendar Year	Covered at 100% of Negotiated Charge	Covered at 100% of Recognized Charges; Deductible waived
Preventive screening and counseling services performed in office		
Office visits for: • **Obesity and/or healthy diet counseling:** 26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet related chronic disease).* • **Misuse of alcohol and/or drugs:** Maximum five (5) visits per calendar year.* • **Use of tobacco products:** Maximum eight (8) visits per calendar year.* • **Sexually transmitted infection counseling:** Maximum two (2) visits per calendar year.** • **Genetic risk counseling for breast and ovarian cancer:** Not subject to any age or frequency limits * For purposes of calculating the visit maximums, each session of up to 60 minutes is equal to one visit. ** For purposes of calculating the visit maximums, each session of up to 30 minutes is equal to one visit.	Covered at 100% of Negotiated Charge	Covered at 100% of Recognized Charges; Deductible waived

PLAN A+: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
Routine Cancer Screenings (whether performed in office or facility)		
Routine Cancer Screenings: Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card. **Lung Cancer Screening:** Maximum one (1) screening every calendar year for individuals age 55 or over. Other lung cancer screenings covered under Outpatient diagnostic testing.	Covered at 100% of Negotiated Charge	Covered at 100% of Recognized Charges; Deductible waived
Preventive care immunizations		
Performed in a facility or at a physician's office Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Covered at 100% of Negotiated Charge	Covered at 100% of Recognized Charges; Deductible waived
Well woman preventive visits routine gynecological exams (including pap smears)		
Performed at a physician's, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN office Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Maximum one (1) visits per Calendar Year.	Covered at 100% of Negotiated Charge	Covered at 100% of Recognized Charges; Deductible waived
Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
• **Preventive care services only.** See the Maternity and Related Newborn Care sections for more information on coverage levels for maternity care under the Plan. • **Comprehensive Lactation support and counseling services:** Facility or office visits. Counseling services maximum six (6) visits per calendar year in either individual or group setting. • **Breast pump supplies and accessories.** See the Breast feeding durable medical equipment section of the booklet for limitations on breast pump and supplies.	Covered at 100% of Negotiated Charge	20% coinsurance (the Plan pays 80% of the Recognized Charge) per visit

PLAN A+: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
FAMILY PLANNING SERVICES		
Female Contraceptives		
• **Female contraceptive counseling services office visit:** Contraceptive counseling services maximum two (2) visits per Calendar Year either in a group or individual setting • **Female contraceptive device** provided, administered, or removed, by a physician during an office visit • **Female voluntary sterilization:** Inpatient or Outpatient services	Covered at 100% of Negotiated Charge	20% coinsurance (the Plan pays 80% of the Recognized Charge)
Voluntary sterilization for males		
Outpatient Services	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)
Abortion		
Outpatient Services	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)
Treatment of Infertility		
Basic Infertility Services	Covered according to the type of benefit and the place where the service is received	
PHYSICIAN AND OTHER HEALTH PROFESSIONAL SERVICES		
Office Hours Visits to Non-Specialist, including surgical services performed in the physician's office Includes services of an internist, general physician, family practitioner or pediatrician	\$25 copay then the Plan pays 100% of the balance of the Negotiated Charge per visit **Allergy Injections performed at a physician's office when you do not see a physician:** Covered at 100% of the Negotiated Charge	30% coinsurance (the Plan pays 70% of Recognized Charges)
Urgent Care Urgent medical care at a non-hospital free standing facility		
Walk-in Clinic Visits (Non-emergency visits) Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic		
MinuteClinic Walk-in clinic inside select CVS Pharmacy® and Target stores. MinuteClinic offers a broad range of services to keep you and your family healthy. MinuteClinic health care providers treat and diagnose a variety of illnesses, injuries and conditions. They can also write prescriptions, when medically appropriate.	Covered at 100% of the Negotiated Charge	Not covered

PLAN A+: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
Telemedicine/Teledoc Online and telephone based physician consultations with TELEDOC providers for the following services ▪ Visit/Consultation with non-specialist physician/provider including behavioral health visits ▪ Visit/Consultations with specialist including dermatology	▪ $25 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit ▪ $40 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit	Not covered
Specialist Office Visits, including surgical services performed in the specialist's office	$40 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit	30% coinsurance (the Plan pays 70% of Recognized Charges)
Outpatient surgery/surgeon and physician surgical services including: ▪ Obesity surgery/surgeon ▪ Oral and maxillofacial treatment (mouth, jaws and teeth) ▪ Reconstructive breast surgery and other Medically Necessity reconstructive surgery	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)
EMERGENCY MEDICAL CARE		
Emergency Room A separate hospital emergency room copayment/payment percentage will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/payment percentage will be waived and your inpatient copayment/payment percentage will apply.	$150 copay per visit	$150 copay per visit You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the member's ID number is on the bill.
Emergency Use of Ambulance Ground, air or water as Medically Necessary	Covered at 100% of the Negotiated Charge	30% coinsurance (the Plan pays 70% of Recognized Charges)
HOSPITAL AND OTHER FACILITY CARE		
Inpatient hospital	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	20% coinsurance (the Plan pays 80% of Recognized Charges)
ALTERNATIVES TO HOSPITAL STAYS		
Outpatient Facility		
Outpatient Facility Charges	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	20% coinsurance (the Plan pays 80% of Recognized Charges)

PLAN A+: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
Home Health Care		
Outpatient Home Health Care Limited to 40 visits per calendar year and three (3) intermittent visits per day provided by a participating home health care agency. One (1) visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	$40 copay then the Plan pays 100% (of the balance of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)
Hospice Care		
Inpatient Facility	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	20% coinsurance (the Plan pays 80% of Recognized Charges)
Outpatient Care Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours a day. Part-time or intermittent home health aide services to care for you up to 8 hours a day	$40 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit	30% coinsurance (the Plan pays 70% of Recognized Charges)
Skilled Nursing Facility		
Inpatient Facility 60 day maximum days per calendar year	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	20% coinsurance (the Plan pays 80% of Recognized Charges)
MATERNITY AND RELATED NEWBORN CARE		
Prenatal care services (other than those payable under the Preventive Care Services)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Delivery and postpartum care Services		
Performed in a facility or at a physician's office	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)
Inpatient Hospital or Birthing Center	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	20% coinsurance (the Plan pays 80% of Recognized Charges)
MENTAL HEALTH TREATMENT: Coverage is provided under the same terms, conditions as any other illness.		
Inpatient Mental Health Treatment		
Inpatient Mental Health Treatment including Residential Treatment Facility Coverage is provided under the same terms, conditions as any other illness.	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	20% coinsurance (the Plan pays 80% of Recognized Charges)
Outpatient Mental Health Treatment		
Outpatient mental health treatment office visits for: ▪ Physician or behavioral health provider ▪ Telemedicine consultation ▪ Cognitive behavioral therapy consultation	$25 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit	30% coinsurance (the Plan pays 70% of Recognized Charges)
Other outpatient mental health treatment includes: ▪ Skilled behavioral health services in the home ▪ Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) ▪ Intensive outpatient program (at least 2 hours per day and at least 6 hours per week of clinical treatment)	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)

PLAN A+: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
Autism spectrum disorder treatment All other coverage for diagnosis and treatment, including behavioral therapy, will be provided the same as any other illness under this plan.	Covered according to the type of benefit and the place where the service is received	
SUBSTANCE USE/RELATED DISORDERS TREATMENT: Coverage is provided under the same terms, conditions as any other illness.		
Inpatient Substance Use Disorder Treatment		
Inpatient: ▪ Substance abuse detoxification during a hospital confinement ▪ Substance abuse rehabilitation during a hospital confinement ▪ Residential treatment facility during a hospital confinement	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	20% coinsurance (the Plan pays 80% of Recognized Charges)
Outpatient Substance Use Disorder Treatment		
Outpatient substance use disorder/abuse office visits for physician or behavioral health provider (includes telemedicine consultation and behavioral therapy consultation)	$25 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit	30% coinsurance (the Plan pays 70% of Recognized Charges)
Other outpatient substance use disorder/abuse services: ▪ Skilled behavioral health services in the home ▪ Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) ▪ Intensive outpatient program (at least 2 hours per day and at least 6 hours per week of clinical treatment)	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)
OUTPATIENT DIAGNOSTIC PROCEDURES		
Diagnostic Complex Imaging Services		
Outpatient Department of a Hospital	Covered at 100%	20% coinsurance (the Plan pays 80% of Recognized Charges)
Other than Outpatient Department of Hospital	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)
Diagnostic Laboratory Work		
Outpatient Department of a Hospital	Covered at 100%	20% coinsurance (the Plan pays 80% of Recognized Charges)
Other than Outpatient Department of Hospital	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)
Diagnostic Radiological Services		
Outpatient Department of a Hospital	Covered at 100%	20% coinsurance (the Plan pays 80% of Recognized Charges)
Other than Outpatient Department of Hospital	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)

PLAN A+: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
OTHER SPECIFIC THERAPIES		
Outpatient Infusion Therapy	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)
Chemotherapy	Covered according to the type of benefit and the place where the service is received.	
Radiation Therapy		
Pulmonary Rehabilitation		
Cardiac Rehabilitation		
Clinical trial therapies (Routine Patient Costs)		
SHORT-TERM REHABILITATION SERVICES		
Outpatient Physical Therapy (Combined with Spinal Manipulation and Acupuncture) Maximum 50 visits per calendar year combined	$25 copay then the Plan pays 100% of the balance of the Negotiated Charge per visit	30% coinsurance (the Plan pays 70% of Recognized Charges)
Outpatient Occupational Therapy	$40 copay then the Plan pays 100% of the balance of the Negotiated Charge per visit	30% coinsurance (the Plan pays 70% of Recognized Charges)
Outpatient Speech Therapy	$40 copay then the Plan pays 100% of the balance of the Negotiated Charge per visit	30% coinsurance (the Plan pays 70% of Recognized Charges)
DURABLE MEDICAL EQUIPMENT (DME) AND DEVICES		
Durable Medical Equipment	$25 copay then the Plan pays 100% of the balance of the Negotiated Charge per visit	30% coinsurance (the Plan pays 70% of Recognized Charges)
Prosthetic Devices	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)
Orthotic Devices	20% coinsurance (the Plan pays 80% of the Negotiated Charge)	30% coinsurance (the Plan pays 70% of Recognized Charges)

PLAN A: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
Deductible (per calendar year) • Unless otherwise indicated, the Deductible must be met prior to benefits being payable. • Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. • The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount	Individual: $250 Per Calendar Year Family: $500 Per Calendar Year	Individual: $2,500 Per Calendar Year Family: $6,250 Per Calendar Year
Payment Limit (per calendar year) • All covered expenses accumulate separately toward the preferred or non-preferred Payment Limit. • Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and Deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. • Pharmacy expenses do not apply towards the Payment Limit. • The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.	Individual: $5,050 Per Calendar Year Family: $10,100 Per Calendar Year	Not Applicable

PLAN A: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
PREVENTIVE CARE AND WELLNESS: Visit maximums only apply to Preventive Care and Wellness benefits that are payable in full In-Network as required by law to be covered as Preventive Benefits. Other Medically Necessary visits, services or supplies will be covered according to the type of benefit and the place where the service is received.		
Routine Physical Exams		
Performed at a physician's, PCP office	Covered at 100% of Negotiated Charge; Deductible waiver	Covered at 100% of Recognized Charges; Deductible waived
Covered Persons through age 21 Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Covered at 100% of Negotiated Charge; Deductible waiver	Covered at 100% of Recognized Charges; Deductible waived
Covered persons age 22 and over Maximum one (1) visit per Calendar Year	Covered at 100% of Negotiated Charge; Deductible waiver	Covered at 100% of Recognized Charges; Deductible waived
Preventive screening and counseling services performed in office		
Office visits for: • **Obesity and/or healthy diet counseling:** 26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet related chronic disease).* • **Misuse of alcohol and/or drugs:** Maximum five (5) visits per calendar year.* • **Use of tobacco products:** Maximum eight (8) visits per calendar year.* • **Sexually transmitted infection counseling:** Maximum two (2) visits per calendar year.** • **Genetic risk counseling for breast and ovarian cancer:** Not subject to any age or frequency limits * For purposes of calculating the visit maximums, each session of up to 60 minutes is equal to one visit. ** For purposes of calculating the visit maximums, each session of up to 30 minutes is equal to one visit.	Covered at 100% of Negotiated Charge; Deductible waiver	Covered at 100% of Recognized Charges; Deductible waived

PLAN A: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
Routine Cancer Screenings (whether performed in office or facility)		
Routine Cancer Screenings: Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card. **Lung Cancer Screening:** Maximum one (1) screening every calendar year for individuals age 55 and over. Other lung cancer screenings covered under Outpatient diagnostic testing.	Covered at 100% of Negotiated Charge; Deductible waiver	Covered at 100% of Recognized Charges; Deductible waived
Preventive care immunizations		
Performed in a facility or at a physician's office Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Covered at 100% of Negotiated Charge; Deductible waiver	Covered at 100% of Recognized Charges; Deductible waived
Well woman preventive visits routine gynecological exams (including pap smears)		
Performed at a physician's, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN office Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Maximum one (1) visits per Calendar Year.	Covered at 100% of Negotiated Charge; Deductible waiver	Covered at 100% of Recognized Charges; Deductible waived
Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
• **Preventive care services only.** See the Maternity and Related Newborn Care sections for more information on coverage levels for maternity care under the Plan. • **Comprehensive Lactation support and counseling services:** Facility or office visits. Counseling services maximum six (6) visits per calendar year in either individual or group setting. • **Breast pump supplies and accessories.** See the Breast feeding durable medical equipment section of the booklet for limitations on breast pump and supplies.	Covered at 100% of Negotiated Charge; Deductible waiver	50% coinsurance (the Plan pays 50% of the Recognized Charge) per visit

PLAN A: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
FAMILY PLANNING SERVICES		
Female Contraceptives		
• **Female contraceptive counseling services office visit:** Contraceptive counseling services maximum two (2) visits per Calendar Year either in a group or individual setting • **Female contraceptive device** provided, administered, or removed, by a physician during an office visit • **Female voluntary sterilization:** Inpatient or Outpatient services	Covered at 100% of Negotiated Charge; Deductible waiver	50% coinsurance (the Plan pays 50% of the Recognized Charge)
Voluntary sterilization for males		
Outpatient Services	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Abortion		
Outpatient Services	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Treatment of Infertility		
Basic Infertility Services	Covered according to the type of benefit and the place where the service is received	
PHYSICIAN AND OTHER HEALTH PROFESSIONAL SERVICES		
Office Hours Visits to Non-Specialist, including surgical services performed in the physician's office Includes services of an internist, general physician, family practitioner or pediatrician	$30 copay then the Plan pays 100% of the balance of the Negotiated Charge per visit; Deductible waived **Allergy Injections performed at a physician's office when you do not see a physician:** Covered at 100%	50% coinsurance (the Plan pays 50% of Recognized 5Charges)
Walk-in Clinic Visits (Non-emergency visits) Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic		
Urgent Care Urgent medical care at a non-hospital free standing facility		
MinuteClinic Walk-in clinic inside select CVS Pharmacy® and Target stores. MinuteClinic offers a broad range of services to keep you and your family healthy. MinuteClinic health care providers treat and diagnose a variety of illnesses, injuries and conditions. They can also write prescriptions, when medically appropriate.	Covered at 100% of the Negotiated Charge	Not covered

PLAN A: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
Telemedicine/Teledoc Online and telephone based physician consultations with TELEDOC providers for the following services ▪ Visit/Consultation with non-specialist physician/provider including behavioral health visits ▪ Visit/Consultations with specialist including dermatology	▪ $30 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit ▪ $50 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit	Not covered
Specialist Office Visits, including surgical services performed in the specialist's office	$50 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Outpatient surgery/surgeon and physician surgical services	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
EMERGENCY MEDICAL CARE		
Urgent Care Facility (at a non-hospital free standing facility)	$30 copay then the Plan pays 100% of the balance of the Negotiated Charge per visit	50% coinsurance (the Plan pays 50% of Recognized Charges)
Emergency Room A separate hospital emergency room copayment/payment percentage will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/payment percentage will be waived and your inpatient copayment/payment percentage will apply.	$150 copay per visit then the Plan pays 100% of the balance of the Negotiated Charge; Deductible waived	$150 copay per visit then the Plan pays 100% of the balance of the Recognized Charges; Deductible waived You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the member's ID number is on the bill.
Emergency Use of Ambulance Ground, air or water as Medically Necessary	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
HOSPITAL AND OTHER FACILITY CARE		
Inpatient Hospital	$500 then the plan pays 100% of the balance of the Negotiated Charge; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Inpatient Hospital Transplant Facility	$500 then the plan pays 70% of the balance of the Negotiated Charge; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)

PLAN A: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
ALTERNATIVES TO HOSPITAL STAYS		
Outpatient Facility		
Outpatient Facility Charges	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Home Health Care		
Outpatient Home Health Care Limited to 40 visits per calendar year and three (3) intermittent visits per day provided by a participating home health care agency. One (1) visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Hospice Care		
Inpatient Facility	$500 then the plan pays 70% of the balance of the Negotiated Charge	50% coinsurance (the Plan pays 50% of Recognized Charges)
Outpatient Care Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours a day. Part-time or intermittent home health aide services to care for you up to 8 hours a day	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Skilled Nursing Facility		
Inpatient Facility 60 day maximum days per calendar year	$500 then the plan pays 70% of the balance of the Negotiated Charge	50% coinsurance (the Plan pays 50% of Recognized Charges)
MATERNITY AND RELATED NEWBORN CARE		
Prenatal care services (other than those payable under the Preventive Care Services)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Delivery and postpartum care Services		
Performed in a facility or at a physician's office	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Inpatient Hospital or Birthing Center	$500 then the plan pays 100% of the balance of the Negotiated Charge	50% coinsurance (the Plan pays 50% of Recognized Charges)
MENTAL HEALTH TREATMENT: Coverage is provided under the same terms, conditions as any other illness.		
Inpatient Mental Health Treatment		
Inpatient Mental Health Treatment including Residential Treatment Facility Coverage is provided under the same terms, conditions as any other illness.	$500 then the plan pays 100% of the balance of the Negotiated Charge; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Outpatient Mental Health Treatment		
Outpatient mental health treatment office visits for: ▪ Physician or behavioral health provider ▪ Telemedicine consultation ▪ Cognitive behavioral therapy consultation	$30 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Other outpatient mental health treatment includes:	30% coinsurance (the Plan pays	50% coinsurance (the Plan pays

PLAN A: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
▪ Skilled behavioral health services in the home ▪ Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) ▪ Intensive outpatient program (at least 2 hours per day and at least 6 hours per week of clinical treatment)	70% of the Negotiated Charge)	50% of Recognized Charges)
Autism spectrum disorder treatment All other coverage for diagnosis and treatment, including behavioral therapy, will be provided the same as any other illness under this plan.	Covered according to the type of benefit and the place where the service is received	
SUBSTANCE USE/RELATED DISORDERS TREATMENT: Coverage is provided under the same terms, conditions as any other illness.		
Inpatient Substance Use Disorder Treatment		
Inpatient: ▪ Substance abuse detoxification during a hospital confinement ▪ Substance abuse rehabilitation during a hospital confinement ▪ Residential treatment facility during a hospital confinement	$500 then the plan pays 100% of the balance of the Negotiated Charge; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Outpatient Substance Use Disorder Treatment		
Outpatient substance use disorder/abuse office visits for physician or behavioral health provider (includes telemedicine consultation and behavioral therapy consultation)	$30 copay then the Plan pays 100% (of the balance of the Negotiated Charge) per visit; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Other outpatient substance use disorder/abuse services: ▪ Skilled behavioral health services in the home ▪ Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) ▪ Intensive outpatient program (at least 2 hours per day and at least 6 hours per week of clinical treatment)	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
OUTPATIENT DIAGNOSTIC PROCEDURES		
Diagnostic Complex Imaging Services		
Outpatient Department of a Hospital	Covered at 100%; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Other than Outpatient Department of Hospital	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Diagnostic Laboratory Work		
Outpatient Department of a Hospital	Covered at 100%; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Other than Outpatient Department of Hospital	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Diagnostic Radiological Services		

PLAN A: Schedule of Benefits/Aetna Choice® POS II		
Plan Features	**How Much You Pay:**	
	In-Network	**Out-of-Network**
Outpatient Department of a Hospital	Covered at 100%	50% coinsurance (the Plan pays 50% of Recognized Charges)
Other than Outpatient Department of Hospital	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
OTHER SPECIFIC THERAPIES		
Outpatient Infusion Therapy	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Chemotherapy	Covered according to the type of benefit and the place where the service is received.	
Radiation Therapy		
Pulmonary Rehabilitation		
Cardiac Rehabilitation		
Clinical trial therapies (Routine Patient Costs)		
SHORT-TERM REHABILITATION SERVICES		
Outpatient Physical Therapy, Spinal Manipulation and Acupuncture Combined 50 visit maximum per calendar year	$50 copay then the Plan pays 100% of the balance of the Negotiated Charge per visit; Deductible waived	50% coinsurance (the Plan pays 50% of Recognized Charges)
Outpatient Occupational and Speech Therapy		
Habilitation Therapy to treat Autism only		
DURABLE MEDICAL EQUIPMENT (DME) AND DEVICES		
Durable Medical Equipment	30% coinsurance (the Plan pays 70% of the Negotiated Charge)	50% coinsurance (the Plan pays 50% of Recognized Charges)
Prosthetic Devices		
Orthotic Devices		

Eligible Health Services

The Plan covers many kinds of health care services and supplies, such as physician care and hospital stays. However, sometimes those services are not covered at all or are covered only up to a limit. For example, physician care generally is covered but physician care for custodial care is never covered. This is an exception (exclusion). Home health care is generally covered but it is a covered benefit only up to a set number of visits a year. This is a limitation. You can find out about these exceptions in the *Exclusions/Exceptions* section, and about the limitations in the S*chedule of Benefits* the immediately preceded this section.

Preventive care and wellness

You will see references to the following recommendations and guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
- United States Preventive Services Task Force
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

- Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost-sharing specific to eligible health services for diagnostic testing.
- Gender-Specific Preventive Care Benefits include eligible health services described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.
- To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your physician or contact Member Services by logging on to your Aetna Navigator® secure member website at www.aetna.com or at the toll-free number on your ID card. This information can also be found at the www.HealthCare.gov website

Routine physical exams

Eligible health services include office visits to your physician, PCP or other health professional for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:

- Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human Immune Deficiency Virus (HIV) infections
- Screening for gestational diabetes for women
- High risk Human Papillomavirus (HPV) DNA testing for women 30 and older

- Radiological services, lab and other tests given in connection with the exam
- For covered newborns, an initial hospital checkup

Preventive care immunizations

Eligible health services include immunizations provided by your physician, PCP or other health professional for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. The Plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

Well woman preventive visits

Eligible health services include your routine:

- Well woman preventive exam office visit to your physician, PCP, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes Pap smears. The Plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury.
- Preventive care breast cancer (BRCA) gene blood testing by a physician and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy.
- Screening for urinary incontinence.

Preventive screening and counseling services

Eligible health services include screening and counseling by your health professional for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Following is more detail about those benefits.

Obesity and/or healthy diet counseling. Eligible health services include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention
- Nutritional counseling

- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

Misuse of alcohol and/or drugs. Eligible health services include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

- Preventive counseling visits
- Risk factor reduction intervention
- A structured assessment

Use of tobacco products. Eligible health services include the following screening and counseling services to help you to stop the use of tobacco products:

- Preventive counseling visits
- Treatment visits
- Class visits
- Tobacco cessation prescription and over-the-counter drugs
    - Eligible health services include FDA-approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a prescriber and the prescription is submitted to the pharmacist for processing. See the Prescription Drug section for details on medications covered under this Plan.

Tobacco product means a substance containing tobacco or nicotine such as cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco

Sexually transmitted infection counseling. Eligible health services include the counseling services to help you prevent or reduce sexually transmitted infections.

Genetic risk counseling for breast and ovarian cancer. Eligible health services include the counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

Routine cancer screenings

Eligible health services include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration

If you need a routine gynecological exam performed as part of a cancer screening, you may go directly to a network OB, GYN or OB/GYN.

Prenatal care

Eligible health services include your routine prenatal physical exams as *Preventive Care*, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

You can get this care at your physician's, PCP's, OB's, GYN's, or OB/GYN's office.

Important note: You should review the benefit under *Maternity and Related Newborn Care* and the *Exclusions* sections of this booklet for more information on coverage for pregnancy expenses under this plan.

Comprehensive lactation support and counseling services

Eligible health services include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast-feeding. Your plan will cover this when you get it in an individual or group setting. The Plan will cover this counseling only when you get it from a certified lactation support provider.

Breast feeding durable medical equipment

Eligible health services include renting or buying durable medical equipment you need to pump and store breast milk as follows:

Breast pump. Eligible health services include:

- Renting a hospital grade electric pump while your newborn child is confined in a hospital.
- The buying of:
  - An electric breast pump (non-hospital grade). Your plan will cover this cost once every three years, or
  - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

Breast pump supplies and accessories. Eligible health services include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose. Including the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Family planning services

Eligible health services include family planning services such as:

Female Contraceptives. Eligible health services include family planning services such as:

Counseling services. Eligible health services include counseling services provided by a physician, PCP, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.

Devices. Eligible health services include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a physician during an office visit.

Voluntary sterilization. Eligible health services include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

The Plan also covers voluntary sterilization for males.

Treatment of infertility

Basic infertility

Eligible health services include seeing a network provider:

- To diagnose and evaluate the underlying medical cause of infertility.
- To do surgery to treat the underlying medical cause of infertility. Examples are endometriosis surgery or, for men, varicocele surgery.

Physicians and other health professionals

Physician services

Eligible health services include services by your physician to treat an illness or injury. You can get those services at the physician's office, in your home or a hospital or from any other inpatient or outpatient facility.

Other services and supplies that your physician may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Physician surgical services

Eligible health services include the services of:

- The surgeon who performs your surgery
- Your surgeon who you visit before and after the surgery
- Another surgeon who you go to for a second opinion before the surgery

Important note: Some surgeries can be done safely in a physician's office. For those surgeries, your plan will pay only for physician services and not for a separate fee for facilities.

Alternatives to physician office visits

The Plan provides coverage for retail, walk-in, or urgent care clinics as well as telemedicine. These give you alternatives to the emergency room at a lower cost and less wait time. They are staffed with nurse practitioners and physician assistants that also give you access to evening and weekend hours when physician's offices are closed.

Retail, Walk-in or Urgent Care Clinic

Eligible health services include health care services provided in walk-in clinics for:

- Unscheduled, non-medical emergency illnesses and injuries
- The administration of immunizations administered within the scope of the clinic's license

Telemedicine - Teladoc

Teladoc is a telephone and online based physician consultation service available 24 hours a day, 365 days a year. It is a convenient and affordable option that allows you to talk to a doctor who can diagnose, recommend treatment and prescribe medication, when appropriate, for many common medical issues. Teladoc does not replace your primary care physician. Rather, it is designed to improve your family's access to quality acute medical care at times when your physician's office is closed or does not have an available appointment time that works with your schedule. At the same time, telemedicine has been shown to help minimize costs for members and benefit plans by preventing unnecessary emergency room and urgent care visits.

Teladoc is the first and largest telemedicine provider in the U.S. It was founded in 2002 and provides more than 12.5 million members with access to U.S.-based, licensed physicians by phone and/or video. While the Teladoc physicians cannot prescribe controlled substances, they can provide general prescription services to your local pharmacy for medical conditions such as cold and flu symptoms, bronchitis, allergies, sinus problems, ear infections and respiratory infections, to name a few. Teladoc is a HIPAA compliant medical service provider and follows NCQA credentialing standards for all physicians. To enroll and begin using Teladoc, simply contact Aetna or visit www.teledoc.com/aetna to learn more.

Emergency Services and Urgent Care

Eligible health services include services and supplies for the treatment of an emergency medical condition or an urgent condition. As always, you can get emergency care from network providers. However, you can also get emergency care from out-of-network providers. Coverage for emergency services and urgent care from out-of-network providers ends when Aetna and the attending physician determine that you are medically able to travel or to be transported to a network provider if you need more care. As it applies to In-Network coverage, you are covered for follow-up care only when your physician or PCP provides or coordinates it. If you use an Out-of-Network Provider to receive follow up care, you are subject to a higher out-of-pocket expense.

In case of a medical emergency. When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your physician or PCP but only if a delay will not harm your health.

Non-emergency condition. If you go to an emergency room for what is not an emergency medical condition, the Plan may not cover your expenses. See the *Exclusion* for *Emergency services and urgent care* section for specific details.

Urgent condition. If you need care for an urgent condition, you should first seek care through your physician or PCP. If your physician or PCP is not reasonably available to provide services, you may access urgent care from an urgent care facility.

Non-urgent care. If you go to an urgent care facility for what is not an urgent condition, the Plan may not cover your expenses.

Hospital and other facility care

Eligible health services include inpatient and outpatient hospital care. The types of hospital care services that are eligible for coverage include:

- Room and board charges up to the hospital's semi-private room rate. Your plan will cover the extra expense of a private room when appropriate because of your medical condition.
- Services of physicians employed by the hospital
- Operating and recovery rooms
- Intensive or special care units of a hospital
- Administration of blood and blood derivatives, but not the expense of the blood or blood product
- Radiation therapy
- Cognitive rehabilitation
- Speech therapy, physical therapy and occupational therapy
- Oxygen and oxygen therapy
- Radiological services, laboratory testing and diagnostic services
- Medications
- Intravenous (IV) preparations
- Discharge planning
- Services and supplies provided by the outpatient department of a hospital.

Outpatient surgery and physician surgical services

Eligible health services include services provided and supplies used in connection with outpatient surgery performed in a surgery center, free-standing facility or a hospital's outpatient department. Important note: Some surgeries can be done safely in a physician's office. For those surgeries, your plan will pay only for physician services and not for a separate fee for facilities.

Home health care

Eligible health services include home health care provided by a home health care agency in the home, but only when all of the following criteria are met:

- You are homebound.

- Your physician orders them.
- The services take the place of your needing to stay in a hospital or a skilled nursing facility, or needing to receive the same services outside your home.
- The services are a part of a home health care plan.
- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy.
- If you are discharged from a hospital or skilled nursing facility after a stay, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement.
- Home health aide services are provided under the supervision of a registered nurse.
- Medical social services are provided by or supervised by a physician or social worker.

Short-term physical, speech and occupational therapy provided in the home are subject to the conditions and limitations imposed on therapy provided outside the home. See the Short-term rehabilitation services and Habilitation therapy services sections and the *Schedule of Benefits*.

Home health care services do not include custodial care.

Hospice care

Eligible health services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:
- Room and board
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a hospital
- Bereavement counseling
- Respite care

Hospice care services provided by the providers below may be covered, even if the providers are not an employee of the hospice care agency responsible for your care:
- A physician for consultation or case management
- A physical or occupational therapist
- A home health care agency for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient prescription drugs
  - Psychological counseling
  - Dietary counseling

Skilled nursing facility

Eligible health services include inpatient skilled nursing facility care. The types of skilled nursing facility care services that are eligible for coverage include:
- Room and board, up to the semi-private room rate
- Services and supplies that are provided during your stay in a skilled nursing facility

Maternity and Newborn Care

Birthing center

A birthing center is a facility specifically licensed as a freestanding birthing center by applicable state and federal laws to provide prenatal care, delivery and immediate postpartum care. Eligible health services include prenatal and postpartum care and obstetrical services from your provider. After your child is born, eligible health services include:

- 48 hours of care in a birthing center after a vaginal delivery
- 96 hours of care in a birthing center after a cesarean delivery

Maternity and related newborn care

Eligible health services include prenatal and postpartum care, obstetrical services and facility charges for maternity and related newborn care. After your child is born, eligible health services include:

- 48 hours of inpatient care in a hospital after a vaginal delivery
- 96 hours of inpatient care in a hospital after a cesarean delivery
- A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier

Coverage also includes the services and supplies needed for circumcision by a provider.

Mental health treatment

Eligible health services include the treatment of mental disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider as follows:

- Inpatient room and board at the semi-private room rate, and other services and supplies related to your condition that are provided during your stay in a hospital, psychiatric hospital, or residential treatment facility.
- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
  - Individual, group and family therapies for the treatment of mental health
  - Other outpatient mental health treatment such as:
    - Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician.
    - Intensive Outpatient Program provided in a facility or program for mental health treatment provided under the direction of a physician.
    - Skilled behavioral health services provided in the home, but only when all the following criteria are met:
      - You are homebound
      - Your physician orders them
      - The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home

- The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications
  - Electro-convulsive therapy (ECT)
  - Transcranial magnetic stimulation (TMS)
  - Psychological testing
  - Neuropsychological testing
  - 23 hour observation
  - Peer counseling support by a peer support specialist. A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Autism Spectrum Disorder

Autism Spectrum Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Eligible health services include the services and supplies provided by a physician or behavioral health provider for the diagnosis and treatment of Autism Spectrum Disorder. Aetna will only cover this treatment if a physician or behavioral health provider orders it as part of a treatment plan.

Aetna will cover early intensive behavioral interventions such as Applied Behavior Analysis. Applied Behavior Analysis is an educational service that is the process of applying interventions:
- That systematically change behavior, and
- That are responsible for observable improvements in behavior.

Substance related disorders treatment

Eligible health services include the treatment of substance abuse provided by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider as follows:
- Inpatient room and board at the semi-private room rate and other services and supplies that are provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Treatment of substance abuse in a general medical hospital is only covered if you are admitted to the hospital's separate substance abuse section or unit, unless you are admitted for the treatment of medical complications of substance abuse.

  As used here, "medical complications" include, but are not limited to, detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.

- Outpatient treatment received while not confined as an inpatient in a hospital, psychiatric hospital or residential treatment facility, including:
  - Office visits to a physician or behavioral health provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes telemedicine consultation)
  - Individual, group and family therapies for the treatment of substance abuse
  - Other outpatient substance abuse treatment such as:
    - Outpatient detoxification
    - Partial hospitalization treatment provided in a facility or program for treatment of substance abuse provided under the direction of a physician.

- Intensive Outpatient Program provided in a facility or program for treatment of substance abuse provided under the direction of a physician.
- Ambulatory detoxifications which are outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications.
- Treatment of withdrawal symptoms
- 23-hour observation
- Peer counseling support by a peer support specialist. A peer support specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a behavioral health provider.

Obesity surgery

Eligible health services include obesity surgery, which is also known as "weight loss surgery." Obesity surgery is a type of procedure performed on people who are morbidly obese, for the purpose of losing weight. Obesity is typically diagnosed based on your body mass index (BMI). To determine whether you qualify for obesity surgery, your doctor will consider your BMI and any other condition or conditions you may have. In general, obesity surgery will not be approved for any member with a BMI less than 35.

Your doctor will request approval in advance of your obesity surgery. The plan will cover charges made by a network provider for the following outpatient weight management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam

Health care services include one obesity surgical procedure. However, eligible health services also include a multi-stage procedure when planned and approved by the plan. Your health care services include adjustments after an approved lap band procedure. This includes approved adjustments in an office or outpatient setting.

Oral and maxillofacial treatment (mouth, jaws and teeth)

Eligible health services include the following oral and maxillofacial treatment (mouth, jaws and teeth) provided by a physician, a dentist and hospital:

- Non-surgical treatment of infections or diseases.
  - Surgery needed to:
    - Treat a fracture, dislocation, or wound.
    - Cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
    - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
    - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- Hospital services and supplies received for a stay required because of your condition.
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed. Your teeth must be free from decay or in good repair, and are firmly attached to your jaw bone at the time of your injury.
  - Other body tissues of the mouth fractured or cut due to injury.

- Crowns, dentures, bridges, or in-mouth appliances only for:
  - The first denture or fixed bridgework to replace lost teeth.
  - The first crown needed to repair each damaged tooth.
  - An in-mouth appliance used in the first course of orthodontic treatment after an injury.
- Accidental injuries and other trauma. Oral surgery and related dental services to return sound natural teeth to their pre-trauma functional state. These services must take place no later than 24 months after the injury.
  - Sound natural teeth are teeth that were stable, functional, and free from decay and advanced periodontal disease at the time of the trauma.
  - If a child needs oral surgery as the result of accidental injury or trauma, surgery may be postponed until a certain level of growth has been achieved.

Reconstructive surgery and supplies

Eligible health services include all stages of reconstructive surgery by your provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your surgery reconstructs the breast where a medically necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes surgery on a healthy breast to make it symmetrical with the reconstructed breast, treatment of physical complications of all stages of the mastectomy, including lymphedema and prostheses.
- Your surgery corrects a gross anatomical defect present at birth. The surgery will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part.
  - The purpose of the surgery is to improve function.
- Your surgery is needed because: treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your surgery will improve function; or performed in conjunction with sex reassignment surgery.

Transplant services

Eligible health services include organ transplant services provided by a physician and hospital. Organ means:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

Network of transplant specialist facilities. The amount you will pay for covered transplant services is determined by where you get transplant services. You can get transplant services from:

- An Institutes of Excellence™ (IOE) facility we designate to perform the transplant you need
- A Non-IOE facility

The National Medical Excellence Program® will coordinate:

- All solid organ and bone marrow transplants
- Other specialized care you need.

Important note: If there is no IOE facility for your transplant type in your network, the National Medical Excellence Program® (NME) will arrange for and coordinate your care at an IOE facility in another one of our networks. If you don't get your transplant services at the IOE facility we designate, your cost share will be higher. Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the NME Program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the covered service is not directly related to your transplant.

Outpatient diagnostic testing

Diagnostic complex imaging services

Eligible health services include complex imaging services by a provider, including:

- Computed tomography (CT) scans
- Magnetic resonance imaging (MRI) including Magnetic resonance spectroscopy (MRS), Magnetic resonance venography (MRV) and Magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including Positron emission tomography (PET) scans
- Other outpatient diagnostic imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work and radiological services

Eligible health services include diagnostic radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests, but only when you get them from a licensed radiological facility or lab.

Chemotherapy

Eligible health services for chemotherapy depends on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your hospital benefit covers the initial dose of chemotherapy after a cancer diagnosis during a hospital stay.

Outpatient infusion therapy

Eligible health services include infusion therapy you receive in an outpatient setting including but not limited to:

- A free-standing outpatient facility
- The outpatient department of a hospital
- A physician in his/her office
- A home care provider in your home

Infusion therapy is the parenteral (i.e. intravenous) administration of prescribed medications or solutions. Certain infused medications may be covered under the outpatient prescription drug coverage. When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

Outpatient radiation therapy

Eligible health services include the following radiology services provided by a health professional:

- Radiological services
- Gamma ray
- Accelerated particles
- Mesons
- Neutrons
- Radium
- Radioactive isotopes

Short-term cardiac and pulmonary rehabilitation services

Eligible health services include the cardiac and pulmonary rehabilitation services listed below.

Cardiac rehabilitation

Eligible health services include cardiac rehabilitation services you receive at a hospital, skilled nursing facility or physician's office, but only if those services are part of a treatment plan determined by your risk level and ordered by your physician.

Pulmonary rehabilitation

Eligible health services include pulmonary rehabilitation services as part your inpatient hospital stay if it is part of a treatment plan ordered by your physician. A course of outpatient pulmonary rehabilitation may also be eligible for coverage if it is performed at a hospital, skilled nursing facility, or physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your physician.

Short-term rehabilitation services

Short-term rehabilitation services help you restore or develop skills and functioning for daily living. Eligible health services include short-term rehabilitation services your physician prescribes. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A hospital, skilled nursing facility, or hospice facility
- A home health care agency
- A physician

Short-term rehabilitation services have to follow a specific treatment plan.

Outpatient cognitive rehabilitation, physical, occupational, and speech therapy

Eligible health services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure.
- Occupational therapy (except for vocational rehabilitation or employment counseling), but only if it is expected to:

- Significantly improve, develop or restore physical functions you lost as a result of an acute illness, injury or surgical procedure, or
- Relearn skills so you can significantly improve your ability to perform the activities of daily living.

- Speech therapy, but only if it is expected to:
  - Significantly improve or restore the speech function or correct a speech impairment as a result of an acute illness, injury or surgical procedure, or
  - Improve delays in speech function development caused by a gross anatomical defect present at birth.
    - Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy and
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function.

Outpatient Spinal Manipulation

Eligible health services include spinal manipulation to correct a muscular or skeletal problem, but only if your provider establishes or approves a treatment plan that details the treatment, and specifies frequency and duration.

Habilitation therapy services

Habilitation therapy services are services that help you keep, learn, or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age). Habilitation therapy services are not covered by the Plan except for the treat of Autism. Eligible health services to treat Autism include habilitation therapy services prescribed by a physician. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist
- A hospital, skilled nursing facility, or hospice facility
- A home health care agency
- A physician

Habilitation therapy services have to follow a specific treatment plan, ordered by your physician.

Outpatient physical, occupational, and speech therapy. Eligible health services include:

- Physical therapy, if it is expected to develop any impaired function.
  - Occupational therapy (except for vocational rehabilitation or employment counseling), if it is expected to develop any impaired function.
  - Speech therapy (except for services provided in an educational or training setting or to teach sign language) is covered provided the therapy is expected to develop speech function as a result of delayed development. (Speech function is the ability to express thoughts, speak words and form sentences).

Acupuncture

Eligible health services include the treatment by the use of acupuncture (manual or electroacupuncture) provided by your physician, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure and
- To alleviate chronic pain or to treat:
  - Postoperative and chemotherapy-induced nausea and vomiting
  - Nausea of pregnancy
  - Postoperative dental pain
  - Temporomandibular disorders (TMD)
  - Migraine headache
  - Pain from osteoarthritis of the knee or hip (adjunctive therapy).

Ambulance service

Eligible health services include transport by professional ground ambulance services:

- To the first hospital to provide emergency services.
- From one hospital to another hospital if the first hospital cannot provide the emergency services you need.
- From hospital to your home or to another facility if an ambulance is the only safe way to transport you.
- From your home to a hospital if an ambulance is the only safe way to transport you. Transport is limited to 100 miles.

The Plan also covers transportation to a hospital by professional air or water ambulance when:

- Professional ground ambulance transportation is not available.
- Your condition is unstable, and requires medical supervision and rapid transport.
- You are travelling from one hospital to another and
  - The first hospital cannot provide the emergency services you need, and
  - The two conditions above are met.

Clinical trial therapies

Experimental or investigational. Eligible health services include experimental or investigational drugs, devices, treatments or procedures from a provider under an "approved clinical trial" only when you have cancer or terminal illnesses and all of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- Aetna determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment.

An "approved clinical trial" is a clinical trial that meets all of these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.

- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Clinical trials (routine patient costs). Eligible health services include "routine patient costs" incurred by you from a provider in connection with participation in an "approved clinical trial" as a "qualified individual" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709. As it applies to in-network coverage, coverage is limited to benefits for routine patient services provided within the network.

Durable medical equipment (DME)

Eligible health services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. Your plan will cover either buying or renting the item, depending on which we think is more cost efficient. If you purchase DME, that purchase is only eligible for coverage if you need it for long-term use.
Coverage includes:

- One item of DME for the same or similar purpose.
- Repairing DME due to normal wear and tear. It does not cover repairs needed because of misuse or abuse.
- A new DME item you need because your physical condition has changed. It also covers buying a new DME item to replace one that was damaged due to normal wear and tear, if it would be cheaper than repairing it or renting a similar item.

The Plan only covers the same type of DME that Medicare covers but some DME items Medicare covers that your plan does not. We list examples of those in the *exclusions* section.

Prosthetic devices

Eligible health services include the initial provision and subsequent replacement of a prosthetic device that your physician orders and administers.

Prosthetic device means:
- A device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness or injury or congenital defects.

Coverage includes:
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage
- Instruction and other services (such as attachment or insertion) so you can properly use the device.

Exclusions: What The Plan Does Not Cover

The Plan covers many health care services and supplies. Following is a list of services and supplies that are NOT covered or are excluded by the Plan.

The Exclusions are grouped together as follows:

- *General Exclusions* list the general services and supplies are not covered under the entire plan.
- Below the *General Exclusions*, in *Exclusions under specific types of care,* is an explanation of exclusions and exceptions for specific types of care or conditions.

General exclusions

Blood, blood plasma, synthetic blood, blood derivatives or substitutes
Examples include:
- The provision of blood to the hospital, other than blood derived clotting factors.
- Any related services including processing, storage or replacement expenses.
- The services of blood donors, apheresis or plasmapheresis.

For autologous blood donations, only administration and processing expenses are covered.

Cosmetic services and plastic surgery. Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body. This cosmetic services exclusion does not apply to surgery after an accidental injury when performed as soon as medically feasible or for medically necessary reconstructive surgery or medically necessary sex reassignment surgery. Injuries that occur during medical treatments are not considered accidental injuries, even if unplanned or unexpected.

Notwithstanding the above, the following are considered cosmetic when used to improve the gender specific appearance of an individual who has undergone or is planning to undergo sex reassignment surgery and will not be covered by the Plan; abdominoplasty; Blepharoplasty; Breast augmentation; Brow lift; calf implants; Electrolysis; Face lift; Facial bone reconstruction; Facial implants; Gluteal augmentation; Hair removal/hairplasty, when medical necessity criteria has not been met; Jaw reduction (jaw contouring); Lip reduction/enhancement; Lipofilling/collagen injections; Liposuction; Nose implants; Pectoral implants; Rhinoplasty; thyroid cartilage reduction (chondroplasty); voice modification surgery; or voice therapy.

Counseling. Marriage, religious, family, career, social adjustment, pastoral, or financial counseling

Court-ordered services and supplies. Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding unless the services are both Medically Necessary and a covered benefit of the Plan.

Custodial care. Examples are:
- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings

- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental care except as specifically described as covered in the *Eligible Expenses* section of this document. Dental services related to:
- The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
- Dental services related to the gums
- Apicoectomy (dental root resection)
- Orthodontics
- Root canal treatment
- Soft tissue impactions
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

Early intensive behavioral interventions. Examples of those services include but are not limited to early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions.

Educational services. Examples of those services are:
- Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, job training and job hardening programs.
- Evaluation or treatment of learning disabilities, attention deficit disorder, developmental, learning and communication disorders, behavioral disorders, or training, regardless of the main cause.
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations. Any health examinations needed:
- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- Because a law requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational. Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs).

Facility charges. For care, services or supplies provided in:
- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Foot care. Services and supplies for:
- The treatment of calluses, bunions, toenails, hammertoes, fallen arches
- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
- Supplies, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
- Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails

Growth/Height care. Services and supplies for:
- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Hearing aids and exams

Jaw joint disorder. Services and supplies for:
- Non-surgical treatment of Temporomandibular joint disorder (TMJ)
- Temporomandibular joint disorder treatment (TMJ) performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ

Maintenance care. Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function except Habilitation Therapy services to treat Autism disorders as described in this document.

Medical supplies – outpatient disposable. Any outpatient disposable supply or device. Examples of these include:
- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Syringes
- Blood or urine testing supplies
- Other home test kits
- Splints
- Neck braces
- Compresses

- Other devices not intended for reuse by another patient

Other primary payer. Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

Personal care, comfort or convenience items. Any service or supply primarily for your convenience and personal comfort or that of a third party.

Pregnancy Charges. Charges in connection with pregnancy care other than for complications of pregnancy and other covered expenses as specifically described in the Eligible health services under your plan section.

Routine exams. Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided as covered under the Preventive Benefits provisions.

Services provided by a family member. Services provided by a spouse, parent, child, step-child, brother, sister, in-law or any household member.

Services, supplies and drugs received outside of the United States. Non-emergency medical services, outpatient prescription drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this booklet.

Sexual dysfunction and enhancement. Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ except for prescriptions of erectile dysfunction drugs as described in the Prescription Drug section of this document.
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services.

Strength and performance. Services, devices and supplies such as drugs or preparations designed primarily for the purpose of enhancing your strength, physical condition, endurance, or physical performance.

Therapies and tests. Services and supplies for:

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

Tobacco cessation. Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, except as specifically provided under the Plan's *Preventive Care and Wellness* benefits as required under healthcare reform. Required medications including nicotine patches and gum are covered under the Prescription Drug program. See the Prescription Drug section of this booklet for details.

Treatment in a federal, state, or governmental entity. Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Vision Care. Vision care services and supplies, including:

- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and
- Laser in-situ keratomileusis (LASIK), including related procedures designed to surgically correct refractive errors

Wilderness Treatment Programs. Wilderness treatment programs (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution).

Work related illness or injuries.
- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

Additional exclusions for specific types of care

Preventive care and wellness
- Services for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by a physician or under his or her direction

Family planning services. Services and supplies for:
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement.

Outpatient surgery and physician surgical services. Services and supplies:
- The services of any other physician who helps the operating physician
- A separate facility charge for surgery performed in a physician's office
- Services of another physician for the administration of a local anesthetic

Home health care. Services and supplies:
- For infusion therapy
- Provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- For transportation
- Provided to a minor or dependent adult when a family member or caregiver is not present

Hospice care. Includes the following:
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling. This includes estate planning and the drafting of a will
- Homemaker or caretaker services. These are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation

- Maintenance of the house

Private duty nursing. (See home health care in the *Eligible health services under your plan and Outpatient and inpatient skilled nursing care* sections regarding coverage of nursing services).

Specific conditions

Maternity and related prenatal care. Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries.

Behavioral health treatment. Services for the following categories (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association):

- Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- Sexual deviations and disorders except for gender identity disorders as otherwise outlined in this document
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs.
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

Mental health /substance use disorders conditions. The following conditions/diagnoses (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association) are not covered by the behavioral health plan:

- Paraphilia's
- Tobacco use disorders and nicotine dependence, except as specifically described in the *Preventive Care and Wellness* benefits as required under Healthcare reform
- Pathological gambling, kleptomania, pyromania
- Specific developmental disorders of scholastic skills (Learning Disorders/Learning Disabilities)
- Specific developmental disorder of motor function
- Specific developmental disorders of speech and language except as specifically covered to treat Autism disorder
- Other disorders of psychological development

Obesity (bariatric) surgery. Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as specifically described as covered in the Eligible Expenses section of this document. In no event will any of the following be covered:

- Weight loss programs (e.g. Weight Watchers, Jenny Craig, meal replacement drinks), dietary instructions, skin reduction procedures/treatment

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications (diet pills are covered under the Prescription drug benefit).
- Hypnosis or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial treatment (mouth, jaws and teeth). Dental implants

Transplant services
- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Treatment of infertility
- All treatment of infertility except Basic services as listed in the *Eligible Health Services* section of this document.
- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father.
  - Cryopreservation of eggs, embryos or sperm.
  - Storage of eggs, embryos, or sperm.
  - Thawing of cryopreserved eggs, embryos or sperm.
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers.
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related.
  - Obtaining sperm for ART services from males who are not covered under this plan.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor oocytes, or donor sperm.
- Reversal of voluntary sterilizations, including follow-up care.
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures.

Specific therapies and tests

Gene Therapy. The Plan does not cover any and all charges for, or related to, gene therapy treatments, whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or not, or are considered experimental or investigational (or not). This exclusion applies to all existing gene therapies, such as Kymriah and Yescarta, Luxturna and Zolgensma, and to all gene therapies that become available at any future date.

Outpatient infusion therapy: The Plan does not cover the following outpatient infusion therapy:

- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Specialty prescription drugs. Drugs that are included on the list of specialty prescription drugs are covered under the Prescription Drug program.

Other services

Ambulance services. Fixed wing air ambulance from an out-of-network provider.

Clinical trial therapies (experimental or investigational). The Plan does not cover expenses associated with clinical trial therapies (experimental or investigational), except as described in the *Eligible Expenses - Clinical trial therapies (experimental or investigational)* section.

Clinical trial therapies (routine patient costs)
- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies).

Durable medical equipment (DME). Examples of these items are:
- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices and massage tables
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems

Nutritional supplements. Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible Expenses* section.

Prosthetic devices. Examples of these items are:
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Prescription Drug Benefits

How the Prescription Drug Benefits Work

Prescription Drug benefits are available to Plan A+ and Plan A Participants and their eligible dependents through Express Scripts. The plan design for both Plan A and Plan A+ are the same.

Your prescription drug benefits, administered by Express Scripts, provides coverage for prescription drugs at retail pharmacies as well as for mail-order. The mail-order drug program, Express Scripts Home Delivery Program, provides home delivery for maintenance or long-term drugs at a reduced cost to you.

You and your covered dependents will receive your own personalized ID card from Express Scripts. You will need this card in order to use your prescription drug benefits. The following provides a summary of what your prescription drug benefits are and how to use them. If you have any questions about your benefits, please reach out to the Fund Office or call Express Scripts directly at (866) 544-2926. You can also visit Express Scripts online by visiting www.express-scripts.com.

Express Scripts will provide a high level of quality service as well as help control the escalating prescription drug costs that the Fund continues to experience. In order to help control costs, Express Scripts uses a network of participating pharmacies. Using a participating pharmacy is generally easier than using a non-participating pharmacy since you do not have to pay the full cost of the prescription up front. In addition, using participating pharmacies results in lower out of pocket costs for both you and the Fund. To find out if your pharmacy participates in the Express Scripts network, simply ask your pharmacist or contact Express Scripts directly.

The Express Scripts Network consists of over 60,000 pharmacies nationally, including chain drugstores like CVS, Rite Aid and Walgreens. You may contact Express Scripts Member Services at (866) 544-2926 to find a pharmacy in your area that participates with Express Scripts. **You can also locate a participating pharmacy on Express Scripts web site at www.expressscripts.com.**

In addition to using a network of participating pharmacies, Express Scripts also utilizes a formulary that sets forth a complete list of covered prescription drugs. Express Scripts frequently updates this formulary based on available therapies, costs, efficacies and generic alternatives. You will be notified by Express Scripts of any change in the formulary and if it has any effect on medication you are currently taking. For more information about the Express Script formulary, please contact Express Scripts directly at (866) 544-2926.

Cost-Sharing

Prescriptions are filled or checked by a registered pharmacist regardless of how you choose to purchase them. You will be required to pay the applicable cost-sharing listed below when you receive a prescription.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS		
Type of Drug	**Retail Pharmacy**	**Mail-Order**
Non-Specialty Prescription Drugs		
ACA Required Preventive Medications	$0	$0
Generic	$20 Copay	$40 Copay
Preferred Brand Name Drugs	$35 Copay	$75 Copay
Non-Preferred Brand Name Drugs	40% Coinsurance ($50 Min/$75 Max)	40% Coinsurance ($100 Min/$150 Max)
Supply of Medication	Up to a 30-day supply	Up to a 90-day supply
SPECIALTY PRESCRIPTION DRUGS Only available from Accredo Specialty Pharmacy		
Specialty Drugs not eligible for the SaveonSP Copayment Assistance Program	Not covered	40% Coinsurance ($300 Max per prescription)
Specialty Drugs Eligible for SaveonSP Copayment Assistance Program when Participating in the SaveonSP Program	Not covered	$0 cost share (see www.saveonsp.com/local802afm for applicable copayment amount)
Specialty Drugs Eligible for SaveonSP Copayment Assistance Program when NOT Participating in the SaveonSP Program	Not covered	see www.saveonsp.com/local802afm for applicable copayment amount
Supply of Medication	N/A	Up to a 90-day supply

Out-of-Pocket Maximum

The Plan will pay 100% of covered participating provider expenses if you or your family reaches the applicable calendar year prescription drug out-of-pocket maximum. Once any covered individual of your family meets the individual limit, the Fund will pay 100% of covered prescription drug expenses incurred at a participating pharmacy for that person for the remainder of the calendar year. Once two individuals of you family meet their individual limit, the Plan will pay 100% for the entire family for the balance of the year.

The participating pharmacy calendar year out-of-pocket maximum is as follows.

PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM This amount may be adjusted annually in accordance with applicable guidance*	
Per Individual	$1,300
Per Family	$2,600

**Does not include copayments incurred for Specialty Drugs eligible for the Saveon SP Copayment Assistance Program for any individuals, whether or not they participate in the program.*

** If a participant selects a brand name prescription drug in circumstances in which a generic drug was available and medically appropriate (as determined by the individual's personal physician), the participant will have to pay an added amount equal to the difference between the cost of the brand name drug and the cost of the generic drug. This added amount paid by the participant does not accumulate to meet the out-of-pocket limit.*

Covered Drugs

The Plan covers a wide range of federal legend prescription drugs (those that bear the legend "Caution: Federal law prohibits dispensing without a prescription") that are written by licensed physicians acting within the scope of their licenses. The Plan does not cover over-the counter drugs except for insulin and diabetic supplies (including insulin syringes/needles and diabetic test strips) and those preventive medications as required under the Affordable Care Act (ACA) or other federal law.

Preventive Benefits Payable under the Prescription Drug Benefit

As required under health care reform, the Plan will pay 100% of the cost of preventative medication such as contraception, when obtained at a participating pharmacy. The list of covered medications is subject to change as ACA guidelines are updated or modified. For the most up-to-date information or more information about which preventive prescription drugs are covered at 100%, please contact Express Scripts.

The following benefits are payable under the Prescription Drug benefit with no Copayments if a prescription is presented to the pharmacist at the time the medication is purchased. Over-the-counter supplements, aspirin or other preventive drugs are only covered with a prescription. Where the FDA has approved one or more therapeutic and pharmaceutical equivalent versions of a preventive drug, device, or product, please note only the generic version (or if there is no generic, only one version of the drug in the Plan's formulary) of the therapeutic and pharmaceutical equivalent version of a drug, device or product will be paid without cost-sharing. You may request coverage for an alternative version of a drug, device and other product if the covered drug, device and other product is not available or is deemed medically inadvisable, as determined by your attending health care provider.

- **Aspirin** to prevent cardiovascular disease when prescribed by a health care Provider.
- **Low-dose aspirin** after 12 weeks of gestation for women who are at high risk for preeclampsia.

- **Oral Fluoride** supplements at currently recommended doses (based on local water supplies) to preschool children through age 5 whose primary water source is deficient in fluoride.
- **Folic Acid** (over the counter/generic only) supplements for women who are planning or capable of pregnancy, containing 0.4 to 0.8 mg of folic acid.
- **FDA-approved contraceptive methods for women**, including contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter.
- **FDA-approved tobacco cessation medications** (including both prescription and over-the-counter medications including cessation treatment for e-cigarettes use) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization including generic nicotine replacement products (nicotine patch, gum and lozenges), brand Nicotrol (inhaler system), brand Nicotrol NS (nasal spray), brand Chantix and generic Zyban. Generics and single source brands are only covered until generics become available. Over-the-counter medications are covered only with a prescription.
- **Bowel Preps** in connection with a screening colonoscopy.
- **Vitamin D supplementation** to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
- **Risk-reducing medications (such as tamoxifen or raloxifene)** for women at increased risk for breast cancer and at a low risk for adverse medication effects.
- **Low-to-moderate-dose statin for the prevention of cardiovascular disease (CVD) events and mortality in adults ages 40-75 years with one or more CVD risk factors** (i.e., dyslipidemia, diabetes, hypertension, or smoking), and a calculated 10-year risk of a cardiovascular event of 10% or greater, when identified as meeting these factors by their treating physician.
- **Pre-exposure Prophylaxis ("PrEP")** for the prevention of HIV infection.
- **Routine adult immunizations and immunization vaccines for children from birth to age 18 as required by the Affordable Care Act**, including administration of such immunizations, are covered for participants and dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation. Includes services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC). Please note that no all participating pharmacies will be able to give all covered vaccines at all times. You should contact the participating retail pharmacy regarding vaccine available and times for administration by a pharmacist. Preventive immunizations are also covered under Medical benefits (see the *Preventive care and wellness* section for details).

Prescription Drug Formulary

The Plan uses the Express Scripts National Preferred Formulary for generic and brand name medications. The formulary is a list of commonly prescribed medications from which your

physician may choose to prescribe. Medications selected for the formulary can safely and effectively treat most medical conditions while helping to keep costs down.

Not all prescription drugs are on the formulary. Non-formulary (or off-formulary drugs) are excluded (i.e., not covered) by the Plan. If you attempt to fill a prescription that it not on the National Preferred Formulary, the pharmacist will generally let you know and work with the prescribing physician or health care practitioner to find a comparable drug on the formulary to ensure coverage. If you fill a prescription for a non-formulary drug, you will pay the entire cost for the prescription.

Generic drugs are usually the lowest cost option available under the Plan. When you purchase generic drugs, you will pay a fixed copay amount for each prescription. Brand drugs will cost you more than generic drugs and are subject to coinsurance with mandatory minimums and maximums. You will pay less for preferred brand drugs than non-preferred brand drugs because the coinsurance minimum and maximums are lower for preferred brand drugs. Also, your share of the cost of a drug depends on whether the drug is a specialty drug. In general, specialty drugs are used to treat a broad array of complex diseases that may require special handling, administration by infusion or injection, or specialized support. In addition, if you are prescribed a specialty drug, it can only be filled through the Accredo specialty pharmacy. Accredo is described in more detail below. All coinsurance and copay amounts are listed in the Schedule of Prescription Drug Benefits below.

Please note that a drug's placement on National Preferred Formulary is subject to change. To find out whether a medication is on the formulary, or whether it is a preferred on non-preferred drug, call Express Scripts at the number listed in the Quick Reference Chart of your SPD or on the back of your ID card, or visit Express Scripts online at www.express-scripts.com.

There may be exceptions for coverage of a non-formulary drug in certain circumstances. Use of drugs that are not on the formulary and thus not covered by the Plan must be approved through Express Scripts' exception process. The requests are evaluated on the basis of medical necessity, the individual's health and safety and the existence of other comparable alternatives. IF you or your physician would like to request an exception, you physician must contact Express Scripts directly – the exception process must be initiated by your physician.

Retail Pharmacy

Participating Pharmacies

To obtain a medication from a participating retail pharmacy, present your prescription and Express Scripts identification card to a pharmacist. The pharmacist will fill your prescription and charge you the applicable Coinsurance or Copayment amount. There are no claims forms to fill out to unless you purchase medication at a non-participating pharmacy.

To find out whether a particular pharmacy participates in Express Scripts network, to locate a participating pharmacy near you, or to obtain a list of participating pharmacies, contact Express Scripts at the number on the back of you identification card of visit Express Scripts online at www.express-scripts.com.

Non-Participating Pharmacies

When you purchase a medication at a non-participating pharmacy, you may pay the full price at the pharmacy and then submit a prescription drug claim form and receipt to Express Scripts for

reimbursement. Mail the completed claim form together with the receipt to the address on the form as soon as possible but no later than 12 months from the date of purchase. You will be reimbursed the amount Express Scripts would have paid a participating pharmacy had you filled the prescription at the participating pharmacy, less the applicable Coinsurance or Copayment amount. This means you are responsible for the difference in cost between the non-participating pharmacy's charges and the non-participating pharmacy's charges.

Claim forms are available from Express Scripts at www.express-scripts.com or by calling the number on the back of your identification card.

Accredo Specialty Pharmacy

Specialty medications are used to treat a broad array of complex diseases that may require special handling, administration by infusion or injection, or specialized patient support. Accredo Specialty Pharmacy is the Plan's exclusive supplier of specialty medications.

If you try to fill your specialty prescription at a retail pharmacy, you will be directed to contact Accredo. In many cases, Accredo will automatically reach out to you to assist you with filling your prescription so that it is covered by the Plan. If you need to contact Accredo, please call (877)-222-7336 or visit www.accredo.com. Note: If you fill a prescription for a specialty drug with a pharmacy other than Accredo, you will have to pay the entire cost for the prescription because no other specialty drug pharmacy is covered by the Plan.

When you fill a prescription for a specialty drug with Accredo, the pharmacy provides you with access to nurses who are trained in specialty medications, pharmacists available 24/7, and coordination of home care and other health care services. Accredo also offers free scheduled delivery of medications (including to a Health Care Professional's office for administration), free supplies such as needles and syringes, and refill reminder calls. All you pay is the applicable Copayment or Coinsurance amount for up to a 90-day supply of specialty drugs as shown in the Schedule of Prescription Drug Benefits above.

SaveonSP Copay Assistance Program

The Fund participates in a program offered by Express Scripts through a company called SaveonSP that is intended to help the Fund and eligible Participants save money on certain specialty medications by obtaining copay assistance from drug manufacturers when such assistance is offered. Under the program, SaveonSP identifies certain high cost specialty drugs that are eligible for copayment assistance through the drug manufacturer, and SaveonSP helps participants enroll in the copay assistance program with the drug manufacturers. The copayment assistance that a Participant receives from the drug manufacturer and other payments under the program are expected to completely cover the Participant's cost share for the specialty drug, so that there is no required payment from a participant. If a Participant's request to enroll in a manufacturer copay assistance program is declined, or if a participant enrolls but the entire copay is not covered by the program, the participant's cost share will still be zero under the terms of this program.

The specialty drugs that are included in this program are classified as non-essential health benefits under the Plan, and the cost of such drugs will not be applied toward satisfying the Participant's out-of-pocket maximum or Deductible in all cases, whether or not you choose to participate in the copayment assistance program. Although the cost of the program's drugs will not be applied toward satisfying a participant's out-of-pocket maximum, the manufacturer and/or

other payments under the program cover the copayment required for these drugs, and there is no cost share charge to the Plan participant. Even in circumstances where a participant applies to enroll in the manufacturer copay assistance program but is denied, or if a manufacturer assistance payment doesn't cover the full cost, there is still no payment due from the participant.

Copays for the program's drugs are reset under the Plan based on the amount of any available manufacturer copay assistance. Therefore, if a participant does not participate in the program, his or her copayment is likely to be higher than it was before the program took effect. The list of program drugs can be found at www.saveonsp.com/local802afm

Mandatory Generic Drug Program

To help you keep your costs down, every time you fill (or refill) your prescription for a brand drug, the pharmacist will automatically check whether a generic equivalent is available and notify you if there is one. You will not sacrifice quality by choosing a generic drug- Generics are approved by the U.S. Food and Drug Administration (FDA) and have the same chemical makeup as the brand-name drug, work the same way in your body, and deliver the same medical benefits.

When you purchase a brand drug that has a generic equivalent, you pay the applicable Coinsurance plus the difference in cost between the generic equivalent and the brand drug. The additional cost applies even if your physician writes "dispense as written" or "DAW" on your prescription for the brand drug. If the prescribing physician believes it is medically necessary for you to take a brand drug when a generic equivalent is available, the prescriber can call Express Scripts to request an exception. Should such a request be approved, you will only have to pay the applicable coinsurance for the brand drug.

If you are prescribed a brand drug that has no generic equivalent, you will only have to pay the applicable coinsurance for the brand drug.

Mail Order Prescriptions

If you are prescribed chronic medication or use "maintenance" prescription drugs, you have the option of participating in the Express Scripts Mail Order program where you can obtain up to a 90-day supply of prescription drugs, rather than a 30-day supply at your local retail pharmacy.

How to Use the Mail-Order Program

If you want to order prescription drugs through the mail order program follow these steps:

- Ask your physician to prescribe a 90-day supply of medication with refills, as may be appropriate
- If you need to begin taking the medication immediately, ask your physician for two prescriptions- one for a short term supply, which can you can fill right away and one for the mail order program
- Complete a Home Delivery Order Form and mail the form, the original mail order prescription (not copy), and the applicable copayment or coinsurance amount to Express Scripts.

To obtain the Home Delivery Order Form or a pre-addressed Express Scripts envelope, or for help determining the applicable copayment or coinsurance amount, visit www.express-scripts.com or contact Express Scripts Member Services.

Note: Non-participating mail order pharmacies are not covered. If you choose to fill a prescription through a non-participating mail order pharmacy, the Plan will not reimburse you for any of your costs.

If you need assistance or have questions about the Express Scripts Mail Order Program, call Member Services at (866) 544-2926 or access their website at www.Express Scripts.com.

Utilization and Clinical Management Programs

Prior Authorization and Drug Quantity Management

The prescription drug benefit covers some medications only if prior authorization is received from Express Scripts or only in limited dosage and quantities. Generally, this is because certain prescriptions have clinical support requirements, are high cost, and/or require special handling and administration. To ensure that the most effective, safe and cost-conscious prescription is chosen, the Fund has implemented advanced prior authorization and drug quantity management programs for certain drugs.

The list of medications that require prior authorization or are limited in dosage and/or quantity are determined by Express Scripts pursuant to its advanced utilization management program and will change from time to time. Since Express Scripts will modify this list from time to time, you should contact Express Scripts to determine whether a particular medication is being managed. If you go to a participating pharmacy, medications affected by these programs will also be identified by Express Scripts when you present the prescription. If you receive a prescription for one of the medications, you should consult with your physician or pharmacist to have them reach out to Express Scripts at (866) 544-2926. If you fill a prescription without the required authorization or approval, your medication will not be covered.

Step Therapy

In a step therapy program, covered drugs are organized in a series of “steps”. The step therapy program is generally geared towards patients who regularly take prescriptions to treat chronic conditions or who are prescribed a high-cost medication where preferred therapeutically equivalent alternatives are available. In order to ensure that the most effective, safe and cost-conscious prescription is chosen, the Fund has implemented step therapy programs for certain categories of drugs.

In essence, the step therapy program requires you to try the preferred alternatives prior to the more expensive non-preferred drug, unless your physician presents an acceptable medical reason for the more non-preferred drug or you have already tried the preferred drug and it was not effective. There are usually three "steps" (generic drug, a preferred formulary drug and a non-preferred formulary drug). However, please note that the Plan already mandates that you select the generic first.

Specialized Management Programs

In collaboration with Express Scripts, the Fund takes advantage of certain specialized programs designed to ensure the safest and most cost-effective treatments are available to you and your family. These special programs usually target a specific or group of drugs that treat a particular condition. The Fund currently participates in a number of these special programs that target

certain cancer, hepatitis C, pulmonary, multiple sclerosis, inflammatory conditions and cholesterol medications. As the prescription drug market evolves, the Fund will continue to work with Express Scripts to review these and any new programs that would benefit Participants of the Fund. If any of these programs, or changes to the programs affect you, Express Scripts will notify you directly. In addition, if you go to a participating pharmacy, medications affected by these programs will also be identified by Express Scripts when you present the prescription.

Exceptions

In certain circumstances, there are exceptions to these management rules. Continued use of drugs that are not covered because of these programs must be approved through Express Scripts' exception process. The requests are evaluated on the basis of medical necessity, the individual's health and safety and the existence of other viable alternatives. If you or your physician would like to request an exception, you should contact Express Scripts at (866) 544-2926. Please note that the exception process must be initiated by your physician.

Prescription Drugs Not Covered

The prescription drug benefit do not cover the following medications:

- All Proton Pump Inhibitors (PPIs), including Aciphex, Prevacid, Protonix, Omeprazole, and Nexium
- Non/Low Sedating Antihistamines (NSAs), including Allegra, Zyrtec, and Clarinex
- Medications that can legally be filled without a prescription or are pharmaceutical alternatives to over-the-counter drugs, except insulin and the preventive benefits listed on page;
- FDA-approved drugs used for purposes other than those approved by the FDA;
- Devices or appliances, support garments, or other non-medical substances or supplies;
- Investigative or experimental drugs, except as required by law;
- Unauthorized refills;
- Drugs administered while confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar facility;
- Fertility drugs, except as required by law;
- Vitamins (other than prenatal vitamins), dietary supplements, and fluoride products, except as required by law;
- Drugs used for cosmetic purposes;
- Drugs used to enhance athletic performance; and
- Prescriptions more than one year from the original date of issue.
- Charges related to gene therapy. The Fund does not cover any charges related to gene therapy, whether those therapies have received approval from the U.S. Food and Drug Administration (FDA) or not or are considered experimental or investigational. See the Definitions section of the SPD for a definition of gene therapy.
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Earplug Benefits

The Fund provides earplugs through several participating earplug providers. Participants who obtain earplugs through a participating provider will be reimbursed up to a maximum of $110 for a set. This benefit is available once every two years. Contact the Fund Office for additional information about participating providers.

Plan A and A+ Vision Benefits

How The Plan Works

The Fund provides Vision benefits through a variety of cooperating vision care providers through General Vision Services and Vision Screening. You and your eligible dependents are automatically eligible for these self-insured vision benefits if you qualify and enroll in either Plan A or A+.

Once a year, you and your dependents are eligible for a routine eye examination, one pair of eyeglasses, and one pair of frames according to the schedule of benefits shown below. For a list of vision providers, you should contact the Fund Office.

What's Covered

Vision benefits are paid according to the following schedule. You will not be reimbursed for any amount over those listed in the Schedule of Benefits below.

Vision Schedule of Benefits

Service	Maximum Allowance Per Calendar Year
Routine Eye Examination (one per Calendar Year)	$15.00
Eyeglass Frames	$11.00
Lenses	
• Single Vision	$13.00
• Bi-Focal	$19.00
• Tri-Focal	$24.00

What's Not Covered

Benefits are not payable for examinations, lenses and frames in excess of one of each (two lenses) per Calendar Year; sunglasses unless they are prescribed to work essentially at all times; tinted-lens glasses unless they are prescribed by an ophthalmologist for medical reasons; and routine annual examinations required by an Employer in connection with the occupation of the covered individual.

Plan B Vision Benefits

How the Plan Works

The Fund provides Vision benefits through and insured contract with EyeMed. If you have Plan B benefits based on your employer contributions, vision benefits will be provided at no cost. If you are covered under Plan A or A+, the Plan B vision benefits are available on a "self-pay" basis.

You can choose from independent doctors and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy to use and to save you money. Once every 12-months, you and your dependents are eligible for a routine eye examination, one pair of eyeglasses, and one pair of frames according to the schedule of benefits shown below. For a list of vision providers, you should contact EyeMed (see the *Contact List* at the beginning of this document for details).

What's Covered

Vision benefits are paid according to the following schedule. You will not be reimbursed for any amount over those listed in the Schedule of Benefits below.

Vision Schedule of Benefits

Service	In-Network Member Cost	Out-Of-Network Reimbursement
Routine Eye Examination with Dilation as Necessary	$10 copay	Up to $30
Contact Lens Fit and Follow up		
• Standard Contact Lens	• Up to $55	• N/A
• Premium Contact Lens	• 10% off retail	• N/A
Retinal Imaging	Up to $39	N/A
Frames	$0 copay; $130 allowance; 80% of charge over $130	Up to $65
Lenses		
• Single Vision	• $20 copay	• Up to $25
• Bi-Focal	• $20 copay	• Up to $40
• Tri-Focal	• $20 copay	• Up to $60
• Standard Progressive Lens	• $85 copay	• Up to $40
• Premium Progressive Lens	• $105 copay - $130 copay	
– Tier 1	– $105 copay	– Up to $40
– Tier 2	– $115 copay	– Up to $40
– Tier 3	– $130 copay	– Up to $0
– Tier 4	– $85 copay	– Up to $40
• Lenticular	• $20 copay	• Up to $60
Lens Options		
• UV Treatment	• $15	• N/A
• Tint (Solid and Gradient)	• $15	• N/A
• Standard Plastic Scratch Coating	• $15	• N/A
• Standard Polycarbonate	• $40	• N/A
• Standard Polycarbonate - under age 19	• $0	• UP to $28
• Standard Anti-Reflective Coating	• $45	• N/A
• Premium Anti-Reflective Coating	• $57-68	• N/A
– Tier 1	– $57	– N/A

- Tier 2 - Tier 3 • Photochromic/Transitions • Polarized • Other Add-Ons and Services	- $68 - 80% of charge • $75 • 20% off retail price • 20% off retail price	- N/A - N/A • N/A • N/A • N/A
Contact Lenses • Conventional • Disposable • Medically Necessary	 • $0 Copay; $130 allowance; 15% off retail price over $130 • $0 Copay; $130 allowance; plus balance over $130 • $0 copay, Paid in Full	 • Up to $104 • Up to $104 • Up to $210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Frequency: • Examination: Once every 12 months • Lenses or Contact Lenses: Once every 12 months • Frame: Once every 24 months		

What's Not Covered

Benefits are not provided from services or materials arising from:

1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear;
4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5) Plano (non-prescription) lenses and/or contact lenses;
6) Non-prescription sunglasses;
7) Two pair of glasses in lieu of bifocals;
8) Services or materials provided by any other group benefit plan providing vision care
9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.

How to Submit an Optical Claim

In-Network providers will fill out and submit your claims paperwork for you. Some Non-participating providers may also provide this service upon your request. If you receive services from a Non-participating provider who does not provide this service, you can submit your own claim directly to EyeMed no more than twelve (12) months after the date of the service.

This is only a snapshot of your benefits. The Certificated of Insurance issued by EyeMed gives you the most details about your dental benefits. It is the legal description of your coverage. Some of the language that specifically details your benefit coverage levels that is included in the Certificate is included in this section. However, you should rely on the Certificate for the most detail about benefits including but not limited to what is covered, exclusions and limitations, coordination of benefits and claims and appeals. Benefit allowance provides no remaining balance for future use within the same benefit year.

Plan B Insured Dental Benefits

The Fund provides Dental benefits through an insured contract with Delta Dental. If you qualify for Plan B benefits based on your employer contributions, vision benefits will be provided at no cost. If you are covered under Plan A or A+, the Plan B dental benefits are available on a "self-pay" basis.

How the Dental Plan Works

You can visit any licensed dentist under this plan, but you will maximize plan value by selecting a Delta Dental PPO1 dentist. PPO network dentists have agreed to reduced contracted rates and can't "balance bill" you for additional fees. Find a dentist at www. deltadentalins.com.

You do not need an ID card to visit a dentist. Just provide your dental office with your name, birth date and enrollee ID or social security number. You may register for Online Services to print an ID card or pull it up on your smartphone at the dentist's office.

What's Covered

Dental benefits are paid according to the following schedule. You will not be reimbursed for any amount over those listed in the Schedule of Benefits below.

Dental Schedule of Benefits		
Deductible	$50 per person / $150 per family each calendar year Deductible waived for Diagnostic & Preventive Services	
Maximums	$1,500 per person each calendar year	
Benefits and Covered Services	**Delta Dental PPO Dentists***	**Non-Delta Dental PPO Dentists****
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100%, deductible waived	100% of Non-Participating Dentist Maximum Plan Allowance, deductible waived
Basic Services Filings and simple tooth extractions	80%	80% of Non-Participating Dentist Maximum Plan Allowance
Endodontics (root canals) Covered under Basic Services	80%	80% of Non-Participating Dentist Maximum Plan Allowance
Periodontics (gum treatment) Covered under Basic Services	80%	80% of Non-Participating Dentist Maximum Plan Allowance
Oral Surgery Covered under Basic Services	80%	80% of Non-Participating Dentist Maximum Plan Allowance
Major Services Crowns, inlays, onlays and cast restorations	50%	50% of Non-Participating Dentist Maximum Plan Allowance
Prosthodontics Bridges, dentures and implants	50%	50% of Non-Participating Dentist Maximum Plan Allowance
TMJ (Temporomandibular Joint)	50%	50% of Non-Participating Dentist Maximum Plan Allowance
Orthodontic Benefits Dependent Children Maximum $1,500 lifetime benefit combined PPO and Non-PPO Dentists	50% to $1500 per lifetime	50% to $1500 per lifetime

* Payment for covered services performed for you by a PPO dentist is calculated based on the PPO maximum plan allowance. PPO dentists have agreed to accept a PPO maximum plan

allowance as the full charge for covered services.

**Payment for services performed for you by a Non-participating Dentist is also calculated by Delta Dental based on the Non-participating Dentist Allowed Amount, which is the lesser of the dentist's submitted fee or the Non-participating Dentist Maximum Plan Allowance. The portion of the Nonparticipating Dentist Allowed Amount payable by Delta Dental ("Delta Dental's Payment") is limited to the applicable percentage shown above.

LIMITATIONS AND EXCLUSIONS

Excluded Benefits

The plan covers a wide variety of dental care expenses, but there are some services for which we do not provide benefits. It is important for you to know what these services are before you visit your dentist.

The plan does not provide benefits for:

1. Surgical procedures including but not limited to reduction of fractures, removal of tumors and removal of impacted teeth are subject to the provisions described in the Other Health Insurance section of this booklet.
2. Treatment or materials with respect to skeletal malformation, except for treatment due to accidental injury to sound natural teeth within 12 months of the accident or treatment necessary due to congenital disease or anomaly, or treatment of enamel hypoplasia (lack of development), except that this exclusion shall not apply to covered dependent children or eligible newborn children so long as such dependent children continue to be eligible. When services are not excluded under this provision as to these dependent children who continue to be eligible, other limitations and exclusions of this section shall specifically apply.
3. Treatment that increases the vertical dimension of an occlusion, replaces tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury.
4. Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury and except for reconstructive surgery necessary because of a congenital disease or anomaly of a covered dependent child which has resulted in a functional defect. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected teeth are excluded.
5. Treatment or materials for which the enrollee would have no legal obligation to pay.
6. Services provided or materials furnished prior to the effective eligibility date of an enrollee under this plan, unless the treatment was a year in duration and completed after the enrollee became eligible if no other limitations shall apply.
7. Periodontal splinting, equilibration, gnathological recordings and associated treatment and extra-oral grafts.
8. Preventive plaque control programs, including oral hygiene instruction programs.
9. Myofunctional therapy, unless covered by the exception in Item 2, above.

10. Temporomandibular joint dysfunction treatment that is medical in nature.
11. Prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia except as a covered benefit in conjunction with a covered oral surgery procedure.
12. Experimental procedures that have not been accepted by the American Dental Association.
13. Services provided or material furnished after the termination date of coverage for which premium has been paid, as applicable to individual enrollees, except this shall not apply to services commenced while the plan was in effect or the enrollee was eligible.
14. Charges for hospitalization or any other surgical treatment facility, including hospital visits.
15. Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.
16. Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.

Limitations

Benefits to enrollees are limited as follows:

Limitation on Optional Treatment Plan. In all cases in which there are optional plans of treatment carrying different treatment costs, payment will be made only for the applicable percentage of the least costly course of treatment, so long as such treatment will restore the oral condition in a professionally accepted manner, with the balance of the treatment cost remaining the responsibility of the enrollee. Such optional treatment includes, but is not limited to, specialized techniques involving gold, precision partial attachments, overlays, implants, bridge attachments, precision dentures, personalization or characterization such as jewels or lettering, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practice.

Limitation on Major Restorative Benefits. If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the enrollee and the dentist select another type of restoration, the obligation of Delta Dental shall be only to pay the applicable percentage of the fee appropriate to the least costly restorative procedure. The balance of the treatment shall be considered a dental treatment excluded from coverage under this plan.

Replacement of crowns, jackets, inlays and onlays shall be provided no more often than once in any five-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period shall be measured from the date on which the restoration was last supplied, whether paid for under the provisions of this plan, under any prior dental care contract, or by the enrollee.

Limitation on Prosthodontic Benefits. Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services, including denture repair and relining, which are necessary to make such appliances fit will be provided as outlined in the section “Covered Benefits.” Prosthodontic appliances and abutment crowns will be replaced only

after five years has elapsed following any prior provision of such appliances and abutment crowns under any plan procedure.

Limitation on Orthodontic Benefits. Orthodontic benefits are limited to devices and procedures for the correction of malposed teeth of dependents up to age 26, through the completion of the procedures; or to the date coverage terminates, which ever occurs first. The obligation of Delta Dental to make monthly or other periodic payments for orthodontic treatment will cease upon termination of treatment for any reason, prior to completion of the procedure. Delta Dental will not make any payment for repair or replacement of orthodontic appliances.

Limitation on Periodontal Surgery. Benefits for periodontal surgery in the same quadrant are limited to once in any five-year period. The five-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this plan, under any prior dental contract, or by the enrollee.

Limitation on Sealants. Treatment with sealants as a covered Service is limited to applications to eight posterior teeth. Applications to deciduous teeth or teeth with caries are not covered Services. Sealants will be replaced only after three (3) years have elapsed following any prior provision of such materials.

Limitation on Occlusal Restorations. Single-surface occlusal restorations of a tooth to which a sealant has been applied within twelve months, and two or three surface restorations within six months, which include occlusal surfaces on which sealants have been placed are not covered Services. If a single-surface occlusal restoration is performed on a tooth from twelve to thirty-six months after a sealant has been applied to that tooth, the obligation of Delta Dental shall be only to pay the fee appropriate to the restoration in excess of the fee paid for the application of the sealant.

How to Submit a Dental Claim

Delta Dental does not require any special claim forms. Most dental offices have standard claim forms available. Participating dentists will fill out and submit your claims paperwork for you. Some Non-participating Dentists may also provide this service upon your request. If you receive services from a Non-participating Dentist who does not provide this service, you can submit your own claim directly to Delta Dental. For your convenience, you can print a claim form from our web site: www.deltadentalins.com. Delta Dental shall not be obligated to pay claims submitted more than twelve (12) months after the date of the Service, unless it can be shown not to have been reasonably possible to submit the claim and the claim was submitted as soon as reasonably possible. Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and mail it to: Delta Dental, P.O. Box 2105, Mechanicsburg, PA 17055-6999.

The Evidence of Coverage document issues by Delta Dental gives you the most details about your dental benefits. It is the legal description of your coverage. Some of the language that specifically details your benefit coverage levels that is included in the Evidence of Coverage is included in this section. However, you should rely on the Certificate for the most detail about benefits including but not limited to what is covered, exclusions and limitations, coordination of benefits and claims and appeals.

Loss of Time Benefit

The Loss of Time benefit applies only to Fund Participants enrolled in Plan A+ or Plan A. The benefit is payable to an eligible Participant who is unable to work in covered employment (i.e., work for which contributions are payable to the Fund) as a result of a non-occupational Injury or Illness.

Amount of the Loss of Time Benefit

The Loss of Time benefit pays $75.00 per week for up to a maximum of thirteen (13) weeks per calendar year. For any period of eligible Illness/Injury that is less than one week (7 days) in duration, the benefit will be prorated ($1/7^{th}$ of $75.00 multiplied by the number of days of disability). A disability will not be considered as having begun more than three (3) days prior to your first physician visit for the condition which caused the Injury/Illness. The Loss of Time benefit will be paid for the period certified by your physician and set forth in the claim form. If the disability continues beyond that period, a new claim form and physician's certification must be submitted

How to Claim Loss of Time Benefits

In order to claim Loss of Time benefits, you must complete a claim form (which can be obtained from the Fund Office) and your physician must certify, on a form provided by the Fund, that (a) your Illness or Injury is not work-related, (b) your Illness or Injury renders you unable to perform work for which contributions are payable to this Fund, and (c) he/she is treating you for such Injury/Illness. The Fund may periodically require you to provide an updated physician's certification. The completed and signed claim form and physician's certificate must be submitted to the Fund Office. Claims may be submitted in person or by mail.

When Loss of Time Benefit Ends

This benefit will end earlier than the date set forth in the physician's certification if any of the following occur: (a) you have received benefits for the maximum period described above, (b) you fail to provide an updated physician's certification upon request, or (c) you return to work in covered employment.

Sick Pay Benefit

The Sick Pay benefit applies to musicians who perform work under the collective bargaining agreement between Local 802 AFM & The Broadway League, Inc. and Buena Vista Theatrical Group Ltd. D/B/A Disney Theatrical Productions ("Broadway/Disney CBA"). This benefit is triggered when you are ill and miss a performance for which you are engaged that is covered by the collective bargaining agreement, provided that you satisfy the accrual and eligibility requirements below.

Accrual and Eligibility

You accrue one (1) paid sick day for every fifty-two (52) performances under the Broadway/Disney CBA during the twelve-month period beginning each Labor Day. For purposes of the benefit, absences for paid vacation are counted as performances played.

You will not receive Sick Pay benefits from the Fund for a sick day until the Fund has received records reflecting that you have performed at least 52 performances under the Broadway/Disney CBA since the last Labor Day; however, if you miss a performance under that collective bargaining agreement before you have played 52 performances, you may file a claim for a Sick Pay benefit for that previous sick day and will receive payment (if approved) after you have played 52 performances. (See below "How to Claim Sick Pay Benefits.")

Make sure you notify your employer of your illness when you give notice of your absence and your substitute.

Amount of the Sick Pay Benefit

The Sick Pay benefit payable for each sick day is equal to the wages you would have been paid had you worked the performance(s) for which you took a sick day, less applicable taxes.

You can earn and receive payment for up to a maximum of eight (8) performances during each twelve-month period beginning each Labor Day. Any sick days accrued, but not used during the twelve months ending each Labor Day are forfeited. However, in the case of a prolonged, continuous illness that lasts for longer than seven (7) consecutive days, you may claim any unused sick pay benefits from the preceding twelve-month period (up to a maximum of 8 days). To claim these additional benefits, you must provide the Fund Office with a physician's certification attesting to your continued illness.

How to Claim Sick Pay Benefits

In order to claim Sick Pay benefits, you must complete an application including the contractor certification. A copy of the application can be obtained from the Fund Office or on the Local 802 website. The completed and signed application must be submitted to the Fund Office within 60 days of your absence due to illness. If your completed application is not received by the Fund Office within that 60-day period, your claim will be denied. Applications may be submitted in person or by mail.

If you are claiming Sick Pay benefits before you have worked 52 performances, your application still must be submitted within 60 days of the date of your absence due to illness, but you will not

receive payment of benefits until the Fund has received records reflecting that you have worked the required fifty-two (52) performances.

File Sick Pay claims with:

Local 802 Musicians Health Fund
322 West 48th Street
New York, NY 10036

If you are claiming benefits due to an extended illness (over 7 days) and wish to use the prior year's unused benefits, you must attach a physician's certification to the benefit claim form.

If you are claiming benefits before you have worked the necessary number of days to have accrued a sick pay day, submit your claim as soon as you return to work, and within 30 days from the date you take the sick day. You will receive payment of benefits as soon as you have worked the necessary number of days to be eligible for this benefit.

Claims and Appeals: Lost of Time and Sick Pay Benefits

The Fund Administrator will make a decision on your claim for benefits within 90 days of receipt of the completed application. If the Fund Administrator determines that special circumstances require an extension of time for processing the claim (up to an additional 90 days), you will be notified in writing (prior to expiration of the initial 90-day period) of the reason(s) for the extension and the date by which the Fund expects to make a determination on the claim.

If the extension is needed because you did not submit the information necessary to decide your claim, the time period in which your claim must be decided will be tolled from the date the extension notice is sent to you until you supply the necessary information.

If your claim is denied in whole or in part, or any other adverse benefit determination is made, you will be notified in writing of the reason(s) for the decision and the specific references to Plan provisions on which the decision is based. The notice will also describe any additional material or information needed to perfect the claim and the reason(s) why such material or information is necessary, together with an explanation of the Fund's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA upon an adverse decision on appeal.

If your claim is denied in whole or in part, or any other adverse benefit determination is made, you may file a request for review of the decision by the Board of Trustees. All requests for review must be submitted within 60 days of your receipt of the claim denial or other adverse benefit determination. In connection with your request for review, you may submit written comments, documents, records, and other information relating to your claim. In addition, you will be provided, upon request and free of charge, with reasonable access to, and copies of, all documents, records and other information relevant to your claim.

The Board of Trustees (or a designated committee of Trustees) will make a decision on your appeal by the date of the next Board meeting that immediately follows the Fund's receipt of your request for review, unless the request for review is submitted to the Fund within 30 days of the date of such meeting, in which case the appeal will be decided no later than the date of the second meeting following the Fund's receipt of the request for review. If special circumstances require an extension of time for making a decision on your appeal, the determination will be made no later than the third Board meeting following the Fund's receipt of your request for review. You will be notified prior to the beginning of the extension period if there is a need for such an extension of time, including a description of the special circumstances and the date by which the Board expects to make a decision. If the extension is needed because you did not submit the information necessary to decide your appeal, the time period in which your appeal must be decided will be tolled from the date the extension notice is sent to you until you supply the necessary information. You will be notified of the Board's (or committee's) decision no later than 5 days after the decision is made.

If your appeal is denied, in whole or in part, or any other adverse benefit determination is made, you will be notified in writing of the specific reason(s) for the decision, including references to the specific Plan provisions on which the decision is based. The notice will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, and a statement describing your right to bring a civil action under Section 502(a) of ERISA upon the adverse decision on appeal.

Claims and Appeals Procedures

This section describes the procedures followed by the Plan in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for Medical, Prescription Drug, Plan A and A+ Vision, Loss of Time, Sick Pay and Earplug benefits. For claims and appeal procedures for insured Plan B Dental and insured Plan B Vision, please refer to the appropriate Certificate of Insurance.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated Participants and dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

For health benefits, you may be able to seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations for claims and appeals for Medical and Prescription Drug benefits either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

General Information

Appropriate Claims Administrators

The Plan Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Benefit Type and Appropriate Claims Administrator	Types of Claims Processed
Medical Benefits Aetna Choice POS II Medical Plan Benefits P.O. Box 981106 El Paso, TX 79998-1106 (877) 843-8498 www.aetna.com	• Pre-Service Claims • Urgent Care Claims and Concurrent claims for precertification and medical management techniques • Post-Service Claims
Prescription Drug Benefits Express Scripts P.O. Box 66773 St. Louis, MO 63166-6773 Member Services: (866) 544-2926 Pharmacist Help Desk: (800) 235-4357 www.express-scripts.com	• Pre-Service Claims • Urgent Care Claims and Concurrent Care Claims • Post-Service Claims for prescriptions filled at Out-of-Network retail pharmacies
Self-Administered Health and Disability Benefits: Plan A and A+ Vision Benefits, Loss of Time and Sick Pay	• Post-Service Plan A and A+ Vision Claims • Loss of Time and Sick Pay Claims

Self-insured Non-Heath Benefits: Earplug Local 802 Musicians Health Fund 322 West 48th Street New York, NY 10036 Phone: (212) 245-4802, ext. 171, 172, 173 and 178 Fax (212) 245-2304	• Earplug Claims

Days

For the purpose of the claim filing and appeal procedures outlined in this chapter, "days" refers to calendar days, not business days.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Adverse Benefit Determination

For the purpose of the initial and appeal claims processes, an Adverse Benefit Determination for a health care claim is defined as:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in this Plan or a determination that a benefit is not a covered benefit; and
- a reduction in a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate; or
- a rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Definition of a Claim

A claim is a request for a Plan benefit made by you or your covered Dependent (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures.

Types of Claims

Health Benefit Claims

Health benefit claims can be filed for Medical, Prescription Drug, Vision and Earplug, Benefits. There are four categories of health claims as described below:

1. **Pre-Service Claims (applicable to Medical and Prescription Drug Benefits):** A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for certain medical/hospital services and prescription drugs.

   Please note that while a Pretreatment Review/Advance Claim Review is suggested for a proposed course of dental treatment that is estimated to be over $150, there is no penalty for failure to obtain this review. If no Pretreatment Review/Advance Claim Review is obtained prior to services being rendered, the claim will be treated as if an Advance Claim Review was obtained. These Reviews are not considered pre-service claims.

2. **Urgent Care Claims (applicable to Medical and Prescription Drug Benefits):** An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider 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. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

3. **Concurrent Claims (applicable to Medical and Prescription Drug Benefits):** A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

4. **Post-Service Claims (applicable to Medical, Prescription Drug, Vision and Earplug Benefits):** A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Loss of Time and Sick Pay Claims

Loss of Time and Sick Pay claims are requests for benefits during a period of disability or illness. Loss of Time and Sick Pay claims are filed after a Participant suffers an illness or disability and benefits are paid if the Claims Administrator determines that the Participant has met the requirements for eligibility for such benefit under the terms of the Plan.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Plan Administrator or Claims Administrator (as applicable);
- Name a specific individual Participant and his/her Social Security Number;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;
- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Claim Filing Deadline

Claims for medical benefits should be filed within 90 days following the date charges were incurred.

Claims for all other health benefits should be filed within twelve (12) months following the date charges were incurred.

See the Loss of Time and Sick Pay sections for claim filing deadlines under those benefits.

Failure to file claims within the time required will not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than eighteen (18) months (or two year for medical benefits) from the date the charges were incurred.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

Initial Claim Decision Timeframes

Health Care Claims – Decision Timeframes

The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

- **Pre-Service Claims (applicable to Medical and Prescription Drug Benefits):** Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

  The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, if a applicable) notification before the expiration of the initial fifteen (15) day determination period.

  If you improperly file a Pre-Service Claim, the Claims Administrator will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

  If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter,

you will have 45 days following your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Administrator receives your response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

- **Urgent Care Claims (applicable to Medical and Prescription Drug Benefits):** In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

  The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to you and your health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

  If you improperly file an Urgent Care Claim, the Claims Administrator will notify you and your health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

  If a claim cannot be processed due to insufficient information, the Claims Administrator will provide you and your health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, you will have not less than 48 hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to you and your health care professional no later than 48 hours after the Claims Administrator receives the specific information or the end or the period given for you to provide this information, whichever is earlier.

- **Concurrent Claims (applicable to Medical and Prescription Drug Benefits):** If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

  A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

  A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

If the Concurrent Care Claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

- **Post-Service Claims (applicable to Medical, Prescription Drug, Vision and Earplug Benefits):** Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

  The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

  If a claim cannot be processed due to insufficient information, the Claim Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Loss of Time and Sick Pay Claims – Decision Timeframes

Claims for Loss of Time and Sick Pay benefits will be decided no later than 45 days after receipt by the Fund Office. You will be notified in writing (or electronically, as applicable) within the 45-day initial determination period if the claim is denied (in whole or in part).

The time for deciding the claim may be extended by 30 days due to circumstances beyond the Claim Administrator's control; provided you are given written (or electronic, as applicable) notification before the expiration of the initial 45-day determination period. A decision will be made within 30 days of the date you are notified of the delay. The period for making a decision may be delayed an additional 30 days if due to matters beyond the control of the Plan, provided you are notified of the additional delay, before the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the decision should be rendered.

If a claim cannot be processed due to insufficient information, you will be notified in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 45-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of

45 days or until the date your written response to the request for information is received. The then has 30 days to make a decision and notify you in writing (or electronically, as applicable).

Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination

If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Identify the claim involved (and for health benefit claims will include the date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (and for health benefit claims, will include a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review for health benefit claims);
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;
- With respect to health and disability benefit claims, the opportunity, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to an internal claim for benefits.
- Provide an explanation of the Plan's internal appeal and external review (for health benefit claims) processes along with time limits and information about how to initiate an appeal and an external review for health benefit claims;
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- With respect to health and disability (Loss of Time and Sick Pay) benefit claims, if the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that a copy of such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request;
- If the denial of a health care or disability (Loss of Time and Sick Pay) claim was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;
- With respect to disability (Loss of Time and Sick Pay) claims, a discussion of the Plan's initial claim discussion, including the basis for disagreeing with: (i) any disability determination or views of a treating physician, or health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented

by the claimant; or (ii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination;

- For Urgent Care health benefit claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and
- With respect to health benefit claims, provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process for health benefit claims.

Notice of Approval of Pre-Service and Urgent Care Claims

If a Pre-Service claim is approved, you will receive written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided in writing (or electronically, as applicable) to you and your health care professional within the applicable timeframe after the Claims Administrator's receipt of the claim.

Internal Appeal Request Deadline

- **Health Care Claims (applicable to Medical, Prescription Drug, Vision and Earplug Benefits):** If an initial health care claim is denied (in whole or in part) and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Under limited circumstances, explained below in the section on External Review, you may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.
- **Loss of Time and Sick Pay Claims:** If an initial Loss of Time or Sick Pay Claim is denied and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following your receipt of an initial notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period.

Internal Appeal Process

Appeal Procedures

To file an internal appeal, you must submit a written statement to the Plan within 180 days of the adverse benefit determination. Your request for an internal appeal must include the specific reasons why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

Appeals for Medical and Prescription Drug Benefits

The Plan maintains a two-level Appeal Process for Medical and Prescription Drug benefits. Both levels of appeals for Medical or Prescription Drug Benefits should be submitted to the Appropriate Claims Administrator listed in the chart on page 11. Appeal requests involving Urgent Care Claims may be made orally by calling the Appropriate Claims Administrator at the telephone number listed in the chart on page 11 or the one found on your ID card.

Appeals for Vision, Earplug, Loss of Time and Sick Pay Benefits

The Plan maintains a one-level Appeals Process for Plan A and A+ Vision, Earplug, Loss of Time and Sick Pay Benefit Claims as well as appeals for eligibility and COBRA. Appeals should be submitted to the Board of Trustees at the address found in chart on page 10.

As a part of its internal appeals process, the Plan will:

- Provide you with the opportunity to submit to the Plan written comments, documents, records, and other information relating to your initial claim for benefits;
- Provide you with the opportunity, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to your initial claim for benefits;
- With respect to health and disability (Loss of Time and Sick Pay) benefit appeals, automatically provide you with a reasonable opportunity to respond to new information by presenting written evidence and testimony;
- Provide you with a full and fair review that takes into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;
- Provide you with respect to health and disability (Loss of Time and Sick Pay) benefit claims, automatically provide you free-of-charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided).New or additional evidence or rationale will be provided to you so that you have a reasonable opportunity, sufficiently in advance of the date on which a notice of an adverse benefit determination upon appeal is required to be provided, to respond to the Plan regarding such evidence. If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed (tolled) until you have had a reasonable opportunity to respond. After you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies.
- Provide you with a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- With respect to health and disability (Loss of Time and Sick Pay) benefit claims appeals, continue coverage during the pendency of the appeal process; and
- In deciding an appeal of any adverse benefit determination regarding a health benefit claim that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, or Medically Necessary or appropriate, the fiduciary will consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and will provide, upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

Appeal Determination Timeframes

- **Pre-Service Claims for Medical and Prescription Drug Benefits.** Under the Plan's two-level appeals process, the Appropriate Claims Administrator will notify you of its first-level determination no later than 15 days after receipt of the appeal. If the first-level review results in an adverse benefit determination, you may request a second level of review by the Appropriate Claims Administrator. You will have 60 days from the date you received the first-level determination to request a second-level appeal review by sending a written request to the Appropriate Claims Administrator shown in the chart on page 11. You will be notified of the second-level appeal determination no later than 15 days after the Plan receives your request for a second-level appeal review. No extension of the Plan's internal appeal review timeframes is permitted.
- **Urgent Care Claims for Medical and Prescription Drug Benefits.** You will be notified of the determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but no later than 72 hours after the Appropriate Claim Administrator's receipt of your (oral or written) request for appeal. A claim involving urgent care is any claim with respect to which the application of the time periods for making non-urgent care could seriously jeopardize your ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to sever pain that cannot be adequately managed without he care or treatment that is the subject of the claim. The plan will defer to determination of your attending provider regarding whether the claim involves urgent care.
- C**oncurrent Claims for Medical and Prescription Drug Benefits.** You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the appropriate Claims Administrator. You will be notified of the determination of your internal appeal as soon as possible before the benefit is reduced or treatment is terminated.
- **Post-Service Claims for Medical/Hospital and Prescription Drugs Benefit Claims.** Under the Plan's two-level appeals process, Aetna will notify you of its first-level determination no later than 30 days after receipt of the appeal. If the first-level review results in an adverse benefit determination, you may request a second level of review by the Appropriate Claims Administrator. You will have 60 days from the date you received the first-level determination to request a second-level appeal review by sending a written request to the Appropriate Claims Administrator shown in the chart on page 11. You will be notified of the second-level

appeal determination no later than 30 days after the Plan receives your request for a second-level appeal review. No extension of the Plan's internal appeal review timeframes is permitted.

- **Post-Service Claims for Vision and Earplug Benefits.** The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Board of Trustees will notify you in writing (or electronically, as applicable) of the benefit determination no later than five calendar days after the benefit determination is made.

Notice of Adverse Benefit Determination Upon Appeal

Any notice of denial of your appeal will include the following:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount);
- The specific reasons for the adverse benefit determination upon appeal, including (i) the denial code (if any) applicable to a health benefit claim and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- Reference the specific Plan provisions on which the denial is based;
- A statement describing the availability, upon request, of the diagnosis code (if applicable) and the treatment code (if applicable) and their corresponding meanings;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;
- A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review regarding the denied internal appeal of a health benefit claim;
- If the denial of a health or disability (Loss of Time or Sick Pay) benefit claim was based on an internal rule, guideline, protocol, or similar criterion, a statement that such rule, guideline, protocol, standard or criteria will be provided free of charge, upon request;
- If the denial of a health benefit or disability (Loss of Time or Sick Pay) claim was based on a medical judgement (Medical Necessity, Experimental, or Investigational), a statement that the Plan will provide an explanation, free of charge, upon request, of the scientific or clinical judgement for the denial, applying the Plan's terms to your medical circumstances;

- With respect to a disability (Loss of Time or Sick Pay) claim, a discussion of the Plan's initial claim discussion, including the basis for disagreeing with (i) any disability determination or views of a treating physician, or health care professional or vocational expert evaluating the claimant, to the extent the Plan does not follow such views as presented by the claimant; or (ii) the views of medical professionals or vocational experts whose advice was obtained on behalf of the Plan, regardless of whether or not the advice was relied upon by the Plan in making an adverse benefit determination;
- If applicable, a statement describing voluntary appeal procedures for prescription drug claims; and
- With respect to a health benefit claim, disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

Limitation on Legal Actions

You may not start a lawsuit to obtain benefits relating to a denied claim until after you have exhausted the Plan's administrative claims and appeals procedures. In other words, you must have requested a review and received a final decision on review of your appeal, or if you have not received such a decision, then the appropriate time frame described above must have elapsed. You may also pursue your remedies under Section 502(a) of ERISA without exhausting the Plan's claims and appeals procedures if the Claims Administrator has failed to follow them.

The decision of the Board (or committee) concerning an appeal shall be final and binding on all parties. A claimant must exhaust these claims and appeals procedures before he or she may bring a legal action seeking payment of benefits under the Plan. Under no circumstances may any legal action be commenced or maintained against the Plan, the Fund, the Trustees, or any representative of the Plan or Fund more than one year following the earlier of : (a) the date that the one-year period of limitations would commence under applicable law, (b) the date upon which the claimant knew or should have known that the claimant did not or would not receive an amount due under the Plan, or (c) the date on which the claimant fully exhausted the Plan's administrative claims and appeals procedures. Any legal or equitable action for benefits under the Plan must be brought in the United States District Court for the Southern District of New York. If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

External Appeals Procedures

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Claims Eligible for the External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; or its determination whether the Plan is complying with the non-quantitative treatment limitations of Code section 9812. The IRO will determine whether a denial involves a medical judgment.
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible for the External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.
- A determination that you or your dependent are not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning you did not request review within the four month deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).
- Claims that relate to benefits other than health care benefits (such as disability benefits, death benefits, and dental/vision benefits that are considered excepted benefits).
- Claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process.
- In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.
- Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:
  - If the Plan waives the requirement that you complete its internal claims and appeals process first.
  - In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.
  - If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation

exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

External Review of a Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must made in writing within four months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, do the following:

- Submit Prescription Drug claims appeals to Express Scripts at the address found in the chart on page 11.
- Submit Medical/Hospital claims appeals to Aetna at the address found in the chart on page 11.

Preliminary Review of a Standard (Non-Urgent Care) Claim by the Plan

Within five business days of the Plan's receipt of your request for external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

- You are or were covered under the Plan at the time the health care item or service was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.
- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to a failure to meet the requirements for eligibility under the terms of the Plan, a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.
- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).
- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review.
- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).)
- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four-month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

Review of A Standard (Not Urgent Care) Claim By The IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, no IRO is eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten business day deadline.
- Within five business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written notice of its decision to you and the IRO within one business day. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo, meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reasons for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meaning, and the reason for the previous denial.
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.
- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.

- A discussion of the principal reasons for the decision, including the rationale for the decision and any evidence-based standards relied upon.
- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.
- A statement that judicial review may be available to you.
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Expedited External Review Of An Urgent Care Claim

You may request an expedited external review in the following situations if:

- The adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

To begin a request for expedited external review, do the following:

- Submit Prescription Drug claims appeals to Express Scripts at the address found in the Quick Reference Chart.
- Submit Medical/Hospital claims appeals to Excellus at the address found in the Quick Reference Chart.

Preliminary Review of an Urgent Care Claim by the Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review of an Urgent Care Claim by the IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, no IRO is eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim de novo meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight hours after it is made.

What Happens After the IRO Decision is Made?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.
- If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA Section 502.

Coordination of Benefits (COB)

When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this Plan when you or your covered dependent has health coverage under more than one plan. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Important Terms for COB

Allowable Expense means a health care service or expense, including, coinsurance and copayments and without reduction of any applicable Deductible, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of reasonable or Recognized Charges, any amount in excess of the highest of the reasonable or Recognized Charges for a specific benefit is not an allowable expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of Negotiated Charges, an amount in excess of the highest of the Negotiated Charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all Plans covering a person are high Deductible Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan's deductible is not an allowable expense, except as to any health expense that may not be subject to the Deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or Recognized Charges and another Plan that provides its benefits or services on the basis of Negotiated Charges, the primary plan's payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different

from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or non-group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the contract that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

- When this Plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
- When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.
- When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different Plan or Plans.

Determining who Pays/Order of Benefits

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

1. **Plan with No COB Provision.** A plan that does not contain a coordination of benefits provision is always primary.
2. **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

   Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:

   (a) *Child of parents who are married or living together.* The primary plan is the plan of the parent whose birthday is earlier in the year.

   (b) *Child of parents separated, divorce, or not living together with court-order*. The primary plan is the plan of the parent the court-order says is responsible for health coverage. If that parent has no coverage, then their spouse's plan is primary.

   (c) *Child of parents separated, divorce, or not living together and court-order sates both parents are responsible for coverage or have joint custody*. The primary plan is the plan of the parent whose birthday is earlier in the year.

   (d) *Child of parents separated, divorce, or not living together and there is no court-order.* The primary plan is the plan of the parent the court-order says is responsible for health coverage. the order of benefits is:

      i The plan of the custodial parent pays first;

      ii The plan of the spouse of the custodial parent (if any) pays second;

      iii The plan of the noncustodial parent pays next; and then

      iv The plan of the spouse of the noncustodial parent pays last.

   For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.
3. **Active Employee or Retired or Laid off Employee.** The plan covering you as an active member (or as a dependent of an active member) is primary to a plan covering you as a laid off or retired member (or as a dependent of a former member).
4. **COBRA or State Continuation Coverage.** The plan covering you as a member or retiree or the dependent of a member or retiree is primary to COBRA or state continuation coverage
5. **Longer or Shorter Length of Coverage.** If none of the above rules determine the order of payment, the plan that has covered the person longer is primary.
6. **Other rules do not apply.** If none of the above rules apply, the plans share expenses equally.

How Coordination of Benefits Works

In determining the amount to be paid when this plan is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced 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 100 percent of the total allowable expense.

In addition, a secondary plan will credit to its plan Deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of this plan, the amount normally reimbursed for covered benefits or expenses under this plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under this plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of this plan and another plan both agree that this plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. Aetna has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, Aetna may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. Aetna will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Aetna is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

When You Have Medicare Coverage

This section explains how the benefits under this Plan interact with benefits available under Medicare.

Medicare, when used in this Booklet, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare. You are eligible for Medicare if you are:

- Covered under it by reason of age, disability, or End Stage Renal Disease
- Not covered under it because you:
  - Refused it;
  - Dropped it; or
  - Failed to make a proper request for it.

If you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, the plan is the primary payor, which means that the plan pays benefits before Medicare pays benefits. Under other circumstances, the plan is the secondary payor, and pays benefits after Medicare.

Which Plan Pays First

The plan is the primary payor when your coverage for the plan's benefits is based on current employment with your employer. The plan will act as the primary payor for the Medicare beneficiary who is eligible for Medicare:

- Solely due to age (e.g., you have attained age 65).
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for Medicare benefits. If you are eligible for Medicare but do not reenroll in both Medicare Part A and Part B after the 30-month coordination period is completed, this Plan will pay benefits as if you have enrolled in both Parts A and B. This means that after the 30-month coordination period is completed, your claims will be reduced as secondary under this Plan regardless of your enrollment status under Medicare. As a result, in order to receive the maximum amount of coverage to which you may be entitled under Medicare, you should enroll in and pay any premiums required for Medicare coverage, including Part B, no later than the end of the 30-month coordination period.

  This provision does not apply if, at the start of eligibility, you were already eligible for Medicare benefits, and the Plan's benefits were payable on a secondary basis.
- Solely due to any disability other than end stage renal disease.

The plan is the secondary payor in all other circumstances.

How Coordination With Medicare Works

When the Plan is Primary

The Plan pays benefits first when it is the primary payor. You may then submit your claim to Medicare for consideration.

When Medicare is Primary

Your health care expense must be considered for payment by Medicare first. You may then submit the expense to Aetna for consideration. Aetna's review is done on a claim-by-claim basis. Charges used to satisfy your Part B Deductible under Medicare will be applied under this Plan in the order received by Aetna. Aetna will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under **This Plan** and other **plans**. **Aetna** has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

Coordination with Medicaid

If your eligible Dependent(s) have coverage from the Fund and Medicaid, the Fund will be the primary insurer.

Subrogation and Right of Recovery Provisions

The provisions of this section apply to all current or former plan Participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile coverage or any first party insurance coverage).

This Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan’s subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the health plan’s subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment, or otherwise, related to treatment for any illness, injury or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source possessing funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan’s recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan’s efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in person injury litigation. Failure to provide this information, failure to assist the plan in pursuit of its subrogation rights, or failure to reimburse the plan from any settlement or recovery you receive may result in the termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan. If you fail to cooperate with the Plan in its efforts to recover such amounts or do anything to hinder or prevent such a recovery, you will cease to be entitled to any further plan benefits. The Plan will also have the right to withhold or offset future benefit payments up to the amount of any settlement, judgment, or recovery you obtain, regardless of whether the settlement, judgment or recovery is designated to cover future medical benefits or expenses.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/ her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

Workers' Compensation

If benefits are paid under the Aetna medical benefits portion of the Plan and Aetna determines you received Workers' Compensation benefits for the same incident, Aetna has the right to recover as described under the Subrogation and Right of Reimbursement provision. Aetna, on behalf of the Plan, will exercise its right to recover against you.

The Recovery Rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily injury or illness was sustained in the course of or resulted from your employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by you or the Workers' Compensation carrier; or

- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this Aetna medical benefits plan, you will notify Aetna of any Workers' Compensation claim you make, and that you agree to reimburse Aetna, on behalf of the Plan, as described above.

If benefits are paid under this Aetna medical benefits plan, and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, Aetna, on behalf of the Plan, has a right to recover from you or your covered dependent an amount equal to the amount the Plan paid.

Recovery of Overpayments

Health Coverage

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery the Plan may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss. Your employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered health benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

The Plan may pay up to $1,000 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release.

When a **PCP** provides care for you or a covered dependent, or care is provided by **a network provider** (**network services or supplies**), the **network provider** will take care of filing claims. However, when you seek care on your own (**out-of-network services and supplies**), you are responsible for filing your own claims.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Names of **physicians**, **dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at www.aetna.com.

Effect of Benefits Under Other Plans

Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, you will be excluded from medical expense coverage (except Vision Care), if any, on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group contract anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

Any extensions of benefits under this plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan providing medical coverage. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- The end of a 90 day period; and
- The date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

Discount Programs

Discount Arrangements

From time to time, the Plan may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

Incentives

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, the Plan may, from time to time, offer to waive or reduce a member's **copayment**, **payment percentage**, and/or a **Deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

Privacy Policy

Confidentiality of Health Care Information

The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the rules issued by the U.S. Department of Health and Human Services.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2004, a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that health plans like this Plan, maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI). Please note that the Aetna maintains policies and procedures as they pertain to the insured medical, prescription drug and dental benefits.

The term "Protected Health Information" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form. PHI does not include health information contained in employment records held by an employer who participates in this Fund in its role as an employer.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which is included at the end of this document as Exhibit A and is also available from the Fund Office. For a copy of Aetna's Notice of Privacy Practices, please contact them at the number that can be found on your ID card.

The Plan, and its Board of Trusteeswill not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

The Plan's Use and Disclosure of PHI: The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations

and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and

c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

Health Care Operations includes, but is not limited to:

a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

f. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

When an Authorization Form is Needed: Generally the Plan will require that you sign a valid authorization form (available from the Fund Office or Aetna) in order for the Plan to use or disclose your PHI other than when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization.

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;

3. Not use or disclose the information for employment-related actions and decisions;

4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. Make PHI available to the individual in accordance with the access requirements of HIPAA;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make available the information required to provide an accounting of PHI disclosures;

9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

- The Plan Administrator,
- Staff designated by the Plan Administrator.
- Business Associates under contract to the Plan including but not limited to the vision claims administrator.

The persons described above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer [whose address and phone number are listed on the Quick Reference Chart in the front of this document].

If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Fund Office or Aetna at the number on your ID card.

In compliance with HIPAA Security regulations, the Plan Sponsor:

1. Has implemented administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Will ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and

Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Important Information You Should Know

Qualified Medical Child Support Orders

The Fund will honor a court order or administrative notice that requires you to provide medical coverage for your child if the Fund determines that the court order or administrative notice is a Qualified Medical Child Support Order (QMCSO). The coverage will be provided in accordance with federal law and the Fund's QMCSO policies and procedures. You may receive a copy of the QMSCO policies and procedures from the Fund Office.

Notice Regarding the Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the patient and the attending physician, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and coinsurance applicable to other medical benefits provided by the Fund. For more information on WHCRA benefits, the amount of coverage available to you, and copayment, Deductible and maximum amounts, please refer to the *Schedule of Benefits*. You may also contact Aetna for additional information.

Nondiscrimination in Health Care

In accordance with Section 2706 of the Public Health Service Act, as amended by the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan or issuer. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

Notice Regarding the Newborns' and Mothers' Health Protection Act

This Fund complies with the protections afforded under the Newborns' and Mothers' Health Protection Act of 1996, which prohibits group health plans and health insurance issuers from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's and newborn's attending provider, after consulting with the mother, from discharging the mother or

her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Aetna for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Recovery of Overpayments

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the retun of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party claims administrator – Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to the same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

RECOVERY OF OVERPAYMENTS

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party claims administrator – Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to the same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Your ERISA Rights

As a Participant in the Local 802 Musicians Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. ERISA provides that all Plan Participants are entitled to the following rights:

Receive Information about Plan and Benefits

You have the right to:

- Examine, without charge, at the Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan. These include insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan. These include insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this booklet for the rules governing your COBRA continuation coverage rights. In addition, the Fund Office will provide you with information governing your COBRA Continuation Coverage rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For example, if you request a copy of plan documents or the latest annual report and do not receive them within 30

days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Fund's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration (EBSA), U.S. Department of labor, listed in your telephone directory, or the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210
866-444-3272

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA). For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact EBSA by visiting their Website at www.dol.gov/ebsa.

Definitions

Calendar Year: the 12-month period beginning January 1 and ending December 31.

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

Collective Bargaining Agreement: means the collective bargaining agreements in force and in effect between the Union and Contributing Employer, together with any modifications or amendments thereto.

Contributions: means the payments made by Employers to the Local 802 Musicians Health Fund

Coordination of Benefits (COB): are the rules and procedures applicable to the determination of how medical and dental benefits are payable when a person is covered by two or more such care plans.

Covered Employment: is work performed under a Collective Bargaining Agreement for which Contributions must be paid to this Fund.

Covered Participant: is any Employee, and that Employee's eligible Spouse or Dependent child, if eligible, who has completed all administrative requirements for enrollment for coverage under the Plan and is actually covered by the Plan.

Eligible or Covered Dependents: means your eligible legal Spouse, domestic partner or your eligible unmarried child as defined in the Eligibility section of this document.

Employee: is an individual who is covered by a Collective Bargaining Agreement or Participation Agreement that requires his or her Employer to make Contributions to this Fund on his or her behalf. Contributions on an Employee's behalf are made for hours worked in accordance with the applicable Agreement.

Employer: means an Employer making Contributions to the Welfare Fund under a Collective Bargaining Agreement or Participation Agreement that requires such Contributions.

Enroll, Enrollment: The process of completing and submitting a written enrollment form indicating that coverage under the Plan is requested by the Employee. An Employee may request coverage for an Eligible Dependent only if that Employee's Dependents are eligible for coverage under the Plan.

ERISA: means the Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. See the section entitled "Your Rights under ERISA" in this booklet for more information.

FMLA: means the Family and Medical Leave Act of 1993, as amended.

HIPAA: means the Health Insurance Portability and Accountability Act of 1996, as amended.

NMHPA: means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

Participation Agreement: is an agreement between the Trustees of this Fund and Local 802, AFM

Glossary of Medical Terms

Aetna

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with Aetna.

Ambulance

A vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Behavioral health provider

An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for mental disorders and substance abuse under the laws of the jurisdiction where the individual practices.

Body mass index

This is a degree of obesity and is calculated by dividing your weight in kilograms by your height in meters squared.

Brand-name prescription drug

A U.S. Food and Drug Administration (FDA) approved prescription drug marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Clinical Trials

Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition, the following criteria must be met:

- The cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
- The trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective non-experimental treatment for the disease exists;
- The person meets all inclusion criteria for the clinical trial and is not treated "off- protocol";
- The trial is approved by the Institutional Review Board of the institution administering the treatment; and
- Coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.
- Routine patient services do not include, and reimbursement will not be provided for:
  - The investigational service or supply itself;
  - Services or supplies listed herein as Exclusions;

- Services or supplies related to data collection for the clinical trial (i.e., protocol- induced costs);
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial Participant.

Copay/copayments

The specific dollar amount or percentage you have to pay for a health care service listed in the Schedule of Benefits.

Cosmetic

Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits

Eligible Expenses that are described in this SPD which meet the requirements for coverage under the terms of this plan, including that they are medically necessary and you received precertification, if required.

Custodial care

Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be custodial care even if it prescribed by a physician or given by trained medical personnel.

Deductible

The amount you pay for eligible health services per Calendar Year before your plan starts to pay as listed in the schedule of benefits.

Detoxification

The process where an alcohol or drug intoxicated, or alcohol or drug dependent, person is assisted through the period of time needed to eliminate the:

- Intoxicating alcohol or drug
- Alcohol or drug-dependent factors
- Alcohol in combination with drugs

This could be done by metabolic or other means determined by a physician. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any applicable licensing standards established by the jurisdiction in which it is located.

Directory

The list of network providers for your plan. The most up-to-date directory for your plan appears at www.aetna.com under the provider search label. When searching provider search, you need to make sure that you are searching for providers that participate in your specific plan. Network providers may only be considered for certain plans.

Durable medical equipment (DME)

Equipment and the accessories needed to operate it, that is:

- Made to withstand prolonged use
- Mainly used in the treatment of an **illness** or **injury**
- Suited for use in the home
- Not normally used by people who do not have an **illness** or **injury**
- Not for altering air quality or temperature
- Not for exercise or training

Effective date of coverage

The date your and your dependent's coverage begins under this booklet as noted in the Fund's records.

Eligible Expenses/Services

The health care services and supplies listed in the *Eligible Expenses* section and not carved out or limited in the *Exclusions* section or in the schedule of benefits**.**

Emergency admission

An admission to a hospital or treatment facility ordered by a physician within 24 hours after you receive emergency services.

Emergency medical condition

A recent and severe medical condition that would lead a prudent layperson to reasonably believe that the condition, illness, or injury is of a severe nature and that, if you don't get immediate medical care, it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus

Emergency services

Treatment given in a hospital's emergency room for an emergency medical condition. This includes evaluation of, and treatment to stabilize an emergency medical condition.

Experimental or investigational

A drug, device, procedure, or treatment that is found to be experimental or investigational because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness** or **injury** involved
- The needed approval by the FDA has not been given for marketing
- A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services
- Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.

Generic prescription drug

A prescription drug with the same dosage, safety, strength, quality, performance and intended use as the brand name product. It is defined as therapeutically equivalent by the U.S. Food and Drug Administration (FDA) and is considered to be as effective as the brand name product.

Gene Therapy

Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems.

Health professional

A person who is licensed, certified or otherwise authorized by law to provide health care services to the public. For example, physicians, nurses, and physical therapists.

Home health care agency

An agency licensed, certified or otherwise authorized by applicable state and federal laws to provide home health care services, such as skilled nursing and other therapeutic services.

Home health care plan

A plan of services prescribed by a physician or other health care practitioner to be provided in the home setting. These services are usually provided after your discharge from a hospital or if you are homebound.

Hospice care

Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure.

Hospice care agency

An agency or organization licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care. These services may be available in your home or inpatient setting.

Hospice care program

A program prescribed by a physician or other health professional to provide hospice care and supportive care to their families.

Hospice facility

An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care.

Hospital

An institution licensed as a hospital by applicable state and federal laws, and is accredited as a hospital by The Joint Commission (TJC).

Hospital does not include a:

- Convalescent facility
- Rest facility
- Nursing facility
- Facility for the aged
- Psychiatric hospital
- Residential treatment facility for substance abuse
- Residential treatment facility for mental disorders
- Extended care facility
- Intermediate care facility
- Skilled nursing facility

Illness

Poor health resulting from disease of the body or mind.

Infertile/Infertility

A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:

- At least 2 abnormal semen analyses obtained at least 2 weeks apart

Injury

Physical damage done to a person or part of their body.

Institutes of Excellence™ (IOE) facility

A facility designated by Aetna in the provider directory as Institutes of Excellence network provider for specific services or procedures.

Intensive Outpatient Program (IOP)

Clinical treatment provided must be no more than 5 days per week, no more than 19 hours per week and a minimum of 2 hours each treatment day of medically necessary services delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a mental disorder or substance abuse issue and may include group, individual, family or multi-family group psychotherapy, psycho educational services, and adjunctive services such as medication monitoring.

Jaw joint disorder

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint,
- A Myofascial Pain Dysfunction (MPD) of the jaw, or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L.P.N.

A licensed practical nurse or a licensed vocational nurse.

Maximum out-of-pocket limit

The maximum out-of-pocket amount for payment of copayments and payment percentage including any deductible, to be paid by you or any covered dependents per Calendar Year for eligible health services.

Medically necessary/Medical necessity

Health care services that a provider exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease
- Not primarily for the convenience of the patient, **physician**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to

produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury** or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.
- Consistent with the standards set forth in policy issues involving clinical judgment.

Mental disorder

A mental disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.

Morbid obesity/Morbidly obese

This means the body mass index is well above the normal range and severe medical conditions may also be present, such as:

- High blood pressure
- A heart or lung condition
- Sleep apnea or
- Diabetes

Negotiated charge

For health coverage, this is either:

- The amount a network provider has agreed to accept
- The amount we agree to pay directly to a network provider or third party vendor (including any administrative fee in the amount paid)

for providing services or supplies to plan members.

For prescription drugs, the negotiated charge is the amount the PBM has established for each prescription drug obtained from a network or participating pharmacy. This negotiate charge may reelect any amounts paid directly to a network/participating pharmacy or third party vendor for the prescription drug, and may include a rebate, additional services or risk charge as set by the PBM.

Network provider

A provider listed in the directory for your plan. However, a NAP provider listed in the NAP directory is not a network provider.

Out-of-network provider

A provider who is not a network provider.

Partial hospitalization treatment

Clinical treatment provided must be no more than 5 days per week, minimum of 4 hours each treatment day. Services must be medically necessary and provided by a behavioral health provider with the appropriate license or credentials. Services are designed to address a mental disorder or substance abuse issue and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Care is delivered according to accepted medical practice for the condition of the person.

Payment Percentage

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

Physician

A skilled health care professional trained and licensed to practice medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy.

Precertification, precertify

A requirement that you or your physician contact Aetna before you receive coverage for certain services. This may include a determination by us as to whether the service is medically necessary and eligible for coverage.

Prescriber

Any provider acting within the scope of his or her license, who has the legal authority to write an order for outpatient prescription drugs.

Prescription

A written order for the dispensing of a prescription drug by a prescriber. If it is a verbal order, it must promptly be put in writing by the network pharmacy.

Prescription drug

An FDA approved drug or biological which can only be dispensed by prescription.

Primary care physician (PCP)

A physician who:

- The directory lists as a PCP
- Is selected by a person from the list of PCPs in the directory
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care physician, an internist, a pediatrician
- Is shown on Aetna's records as your PCP

Provider(s)

A physician, other health professional, hospital, skilled nursing facility, home health care agency or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric hospital

An institution specifically licensed or certified as a psychiatric hospital by applicable state and federal laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse, mental disorders (including substance-related disorders) or mental illnesses.

Psychiatrist

A psychiatrist generally provides evaluation and treatment of mental, emotional, or behavioral disorders.

Recognized charge

The amount of an out-of-network provider’s charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage. The recognized charge depends on the geographic area where you receive the service or supply. Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If Aetna determines they need more data for a particular service or supply, they may base rates on a wider geographic area such as an entire state.

Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. Aetna updates its systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, they use one or more of the items below to determine the rate:

- The method CMS uses to set Medicare rates
- What other providers charge or accept as payment
- How much work it takes to perform a service
- Other things as needed to decide what rate is reasonable for a particular service or supply

The table below shows the method for calculating the recognized charge for specific services or supplies:

Service or supply	Recognized charge
Professional services and other services	150% of the Medicare allowable rate
Services of hospitals and other facilities	150% of the Medicare allowable rate

Important note: If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.

Exceptions. Aetna may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
- The rate may also exclude other payments that CMS may make directly to hospitals or other providers. It also may exclude any backdated adjustments made by CMS.
- For anesthesia, the rate is 105% of the rates CMS establishes for those services or supplies.
- For laboratory, the rate is 75% of the rates CMS establishes for those services or supplies.
- For DME, the rate is 75% of the rates CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than prescription drug benefits, the rate is 100% of the rates CMS establishes for those medications.

Recognized charge does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by an out-of-network provider, unless that out-of-network provider is an assistant surgeon for your surgery
- Not available from a network provider

Aetna will calculate your cost share for involuntary services in the same way as they would if you received the services from a network provider

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP provider. NAP providers are out-of-network providers and third party vendors that have contracts with us but are not network providers. Except for involuntary services, when you get care from a NAP provider your out-of-network cost sharing applies.

Reimbursement policies. Aetna reserves the right to apply its reimbursement policies to all out-of-network services including involuntary services. These reimbursement policies may affect the recognized charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided

- The educational level, licensure or length of training of the provider

Aetna's reimbursement policies are based on itsreview of:
- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in the relevant clinical areas

Aetna uses commercial software to administer some of these policies. The policies may be different for professional services and facility services.

R.N.

A registered nurse.

Residential treatment facility (mental disorders)

An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for mental health residential treatment programs. And is credentialed by Aetna or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating mental disorders:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week.
- The patient must be treated by a psychiatrist at least once per week.
- The medical director must be a psychiatrist.
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution).

Residential treatment facility (substance abuse)
An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for substance abuse residential treatment programs. And is credentialed by Aetna or accredited by one of the following agencies, commissions or committees for the services being provided:
- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Chemical Dependence Residential Treatment Programs:

- A behavioral health provider or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming.
- The medical director must be a physician.
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution).

In addition to the above requirements, for Chemical Dependence **Detoxification** Programs within a residential setting:

- An R.N. must be onsite 24 hours per day for 7 days a week within a residential setting.
- Residential care must be provided under the direct supervision of a physician.

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

Semi-private room rate

An institution's room and board charge for most beds in rooms with 2 or more beds. If there are no such rooms, Aetna will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility

A facility specifically licensed as a skilled nursing facility by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation hospitals, and portions of a rehabilitation hospital and a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- Custodial care services
- Ambulatory care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of mental disorders or substance abuse.

Skilled nursing services

Services provided by an R.N. or L.P.N. within the scope of his or her license.

Specialist

A physician who practices in any generally accepted medical or surgical sub-specialty

Stay

A full-time inpatient confinement for which a room and board charge is made.

Substance abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions you cannot attribute to a mental disorder that are a focus of attention or treatment or an addiction to nicotine products, food or caffeine intoxication.

Surgery center

A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient surgery services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Surgery or surgical procedures

The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint, injection of sclerosing solution, or otherwise physically changing body tissues and organs.

Telemedicine

A consultation between you and a provider who is performing a clinical medical or behavioral health service. Services can be provided by:

- Two-way audiovisual teleconferencing;
- Telephone calls , except for behavioral health services
- Any other method required by state law

Terminal illness

A medical prognosis that you are not likely to live more than 12 months.

Urgent care facility

A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.

Urgent condition

An illness or injury that requires prompt medical attention but is not an emergency medical condition.

Walk-in clinic

A free-standing health care facility. Neither of the following should be considered a walk-in clinic:

- An emergency room
- The outpatient department of a hospital

Discount programs

Discount arrangements

Aetna can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called "third party service providers". These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. Aetna has the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and Other Incentives

The Plan may encourage you to access certain medical services, use tools (online and others) that enhance your coverage and services, and continue participation as Participant through incentives. You and your doctor can talk about these medical services and tools and decide if they are right for you. In connection with a wellness or health improvement program, we may provide incentives based on your participation and your results. Incentives may include but are not limited to:

- Modifications to copayment, Deductible, or coinsurance amounts
- Premium discounts or rebates
- Contributions to a health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards or
- Any combination of the above.

Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

Information About Your Plan and Benefits

As a Participant in the Local 802 Musicians Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

- Examine, without charge, at the Fund Office and at other specified locations, such as the union hall, all Plan documents, including collective bargaining agreements, and copies of all documents, such as detailed annual reports and Plan descriptions filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a "Qualifying Event." You or your dependents may have to pay for such coverage. The Fund recommends that you review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Plan Administrative Information

Plan Name

Local 802 Musicians Health Fund

Plan Type

The Plan is an employee welfare benefit plan maintained to provide group health and other welfare benefits to eligible Participants and their eligible family members.

Plan Year

The Plan Year is October 1 through September 30.

Plan Identification Numbers

The number assigned to the Plan is 501. The Employer Identification Number (EIN) assigned to the Board of Trustees by the Internal Revenue Service is 13-1801294.

Plan Administrator

The Board of Trustees is the "Plan Administrator" under ERISA. The Board has designated Ms. Gloria McCormick as the Fund Administrator to handle the day-to-day operations of the Fund. She is also the agent for service of legal process under ERISA.

Gloria McCormick
Fund Administrator
Local 802 Musicians Health Fund
322 West 48th Street
New York, NY 10036
(212) 245-4802

Legal process may also be served on any individual Trustee at the above addresses.

For disputes arising under those portions of the Plan insured by Empire BlueCross BlueShield, service of legal process may be made upon Empire at one of their local offices or upon the official of the Insurance Department in the state in which you reside.

Aetna handles administration of the self-insured medical benefits, Express Scripts handles administration of the prescription drug benefits, Empire Blue Cross Blue Shield handles administration of the insured HMO benefits, Eye Med handles the administration of the insured Plan B vision benefits and Delta Dental handles the administration of the insured Plan B dental benefits. The Fund Office administers the loss of time, sick pay, earplug and Plan A and Plan A+ vision.

Documents Governing the Plan

If you want to review or receive copies of documents governing the Plan, contact the Fund Administrator at the Fund Office. You may be charged a reasonable fee for copies of any

documents you request (other than this Summary Plan Description and any Summaries of Material Modifications). However, you may examine these documents without charge by visiting the Fund Office during normal working hours.

Plan Funding

The Local 802 Musicians Health Fund is funded primarily by Employer contributions made pursuant to collective bargaining agreements between various Employers in the musical engagement industry and the Associated Musicians of Greater New York, Local 802 A.F.M. (the American Federation of Musicians). In addition, employee contributions are required for some benefits, and certain Fund Participants may have the option of contributing to the Fund (so as to increase their level of eligibility) in accordance with the terms of the collective bargaining agreement that governs their employment and the Fund's rules.

Contributions (and investment income thereon) are used to fund the self-insured benefits provided by the Fund and/or pay premiums for insured benefits. Contributions, income and reserves accumulated by the Fund are held in a trust for the purpose of providing the Plan's health and other welfare benefits to covered Participants and their eligible dependents and for the purpose of paying reasonable administrative expenses.

Contributing Employers

As noted, participating Employers contribute to the Fund on behalf of their eligible employees in amounts specified in the applicable collective bargaining agreements. A copy of any such collective bargaining agreement may be obtained by Participants and beneficiaries upon written request to the Fund Office, and the agreements are available for examination at the Fund Office. Upon written request, the Fund Office will also provide you with information as to whether a particular Employer contributes to the Fund and/or a list of sponsoring Employers and employee organizations.

Plan Amendment or Termination

The Board of Trustees intends to continue the Fund indefinitely. However, the Trustees reserve the right, in their sole and absolute discretion, to change, modify, amend or terminate the Plan, in whole or in part, at any time and for any reason, subject to the provisions of any applicable collective bargaining agreements. Resolutions to amend the Fund's rules are made by the Board of Trustees and become effective on the date as specified in the resolution.

Plan benefits and eligibility rules for eligible Participants and dependents:

- are not guaranteed or otherwise vested;
- may be changed or discontinued by the Board of Trustees;
- are subject to the Plan documents and rules adopted by the Board of Trustees;
- are subject to the Trust Agreement which establishes and governs the Fund's operations; and
- are subject to the provisions of any applicable insurance policy and contracts.

The Fund also may be terminated by the Trustees when there is no longer in effect an agreement between the contributing Employers and the Union requiring contributions to the Fund. Upon termination of the Fund, the Trustees will apply the assets of the Fund to provide benefits or

otherwise carry out the purposes of the Fund in an equitable manner until the Fund's assets have been exhausted.

Board of Trustees' Discretion and Authority

The Board of Trustees (and its designees) has the sole and absolute discretionary authority to construe and interpret the terms of the Fund's plan of benefits, including this Summary Plan Description, insurance certificates, and any or all provisions, rules, regulations, and procedures adopted by the Board. The Trustees reserve the right to change or discontinue (1) the types and amounts of benefits provided under the Fund and/or (2) the eligibility rules, subject to the terms of any applicable collective bargaining agreements. The nature and amount of the Fund's benefits are always subject to the actual terms of the Plan as it exists at the time claims are incurred.

No Guarantee of Employment

Your coverage under the Fund does not constitute a guarantee of employment and you are not vested in the benefits described in this SPD.

ATTENTION

This booklet contains only a brief summary of the benefits provided by the plan. For full details of your coverage, you should contact the Plan Office, where the Plan's group insurance policies are on file.

To determine your eligibility or for other information regarding claims or forms, please call or write:

LOCAL 802
MUSICIANS HEALTH FUND
322 West 48th Street
New York, New York 10036
Phone: (212) 245-4802