Bakers Union and FELRA

Health and Welfare Fund

Plans 1, 2, 3, and 4

SUMMARY PLAN DESCRIPTION
July 2016

The Administrative Manager

- Receives Participating Employer/employee contributions
- Keeps eligibility records and processes claims
- Provides information about the Fund

The Administrative Manager is
Associated Administrators, LLC

Fund Offices
911 Ridgebrook Road
Sparks, Maryland 21152-9451-9451
(410) 683-6500 or Toll Free (866) 662-2537

4301 Garden City Drive, Suite 201
Landover, Maryland 20785-6102
(301) 459-3020 or Toll Free (866) 662-2537

Hours
8:30 a.m. to 4:30 p.m., Monday through Friday

IMPORTANT

The terms "Plan 1," "Plan 2," "Plan 3," and "Plan 4" is used throughout this booklet.

- Plan 1 refers to Full-Time Local 118 *Participant*s hired **before** October 17, 2004 and to Full-Time Local 68 *Participant*s hired **before** October 31, 2004.
- Plan 2 refers to Full-Time Local 118 *Participant*s hired **on or after** October 17, 2004 and to Full-Time Local 68 *Participant*s hired **on or after** October 31, 2004.
- Plan 3, effective January 1, 2015, refers to Full-Time Local 118 *Participant*s hired **on or after** December 9, 2014 and to Full-Time Local 68 *Participants* hired **on or after** November 13, 2014, and all Part-Time *Participant*s who were hired to work an undetermined number of hours per week and were entitled to be paid for an average of at least 28 hours per week during the first 12 months of employment ("initial measurement period").
- Plan 4 effective January 1, 2015 refers to Part-Time *Participants* that were hired to work an undetermined number of hours per week and were entitled to be paid for an average less than 28 hours per week during the first 12 months of employment ("initial measurement period").

DEAR PARTICIPANT,

The Bakers Union and FELRA Health and Welfare Fund ("the *Fund*" or "the Plan") was established as a result of collective bargaining between your *Union* and your *Participating Employer.* The contribution rate paid by your *Participating Employer* provides the benefit you receive. An equal number of *Union* and *Employer Trustees* have been appointed to administer the *Fund*, and they serve without compensation. Their authority includes the right to make rules about your eligibility for benefits and the level of benefits available. The *Trustees* may amend the rules and benefit levels at any time. The *Trustees* delegate authority to professionals who help them manage the Plan:

- An *Administrative Manager* (referred to as the "*Fund Office*" in this booklet) receives *Participating Employer* contributions, keeps eligibility records, pays claims, and assists *Fund Participant*s in getting their benefits. Some benefits are paid directly by the *Fund*; others are provided by insurance carriers or other providers and the *Fund* pays premiums. Benefits are limited to *Fund* assets for all *Fund*-provided benefits.
- An Investment Manager invests the *Fund's* assets to achieve a reasonable rate of investment return. *Fund* Counsel provides legal advice.
- An independent Certified Public Accountant audits the *Fund* each year. Periodic payroll audits are also performed for each *Participating Employer*.

You will be notified of any material modifications (changes) to this document, the Summary Plan Description ("SPD"), as required by federal law. If there are any differences between this SPD booklet--which is intended as an explanation of your benefits--and the formal agreements between the *Fund* and insurance carriers or other providers of service, the formal agreements will govern.

The *Trustees* are pleased to offer the protection of this Plan to *Participant*s.

Sincerely,

BOARD OF TRUSTEES

TABLE OF CONTENTS

FACTS ABOUT THE PLAN

Plan Name
Bakers Union and FELRA Health and Welfare Fund

Plan Sponsor
Board of *Trustees* of the Bakers Union and FELRA Health and Welfare Fund, 911 Ridgebrook Road, Sparks, MD 21152-9451, (866) 662-2537. A list of *Participating Employers* and *Union*s is on page 6.

***Employer* Identification Number**	**Plan Number**
26-0000485	501

Type of Plan
This is a welfare plan designed to provide health benefits such as life, accidental death and dismemberment, Hospitalization, medical, surgical, mental health, accident & sickness, prescription drug, optical and dental benefits.

Type of Administration
Contract Administration. The Board of *Trustees* has contracted with Associated Administrators, LLC to provide administrative management services.

Name of Plan Administrator
Board of *Trustees* of the Bakers Union and FELRA Health and Welfare Fund

Agent of Service for Legal Process
Associated Administrators, LLC or any Trustee at the following address:

Bakers Union and FELRA Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

Sources of Contribution

Sources of the contributions to the *Fund* are *Participating Employers* pursuant to the terms of their *Collective Bargaining Agreements* and self-payments made by *Participant*s and/or *Dependent*s in certain circumstances.

Funding Medium

All assets are held in trust. Benefits and reasonable administrative expenses are paid from the assets of the Trust. The *Fund's* assets and reserves are held by PNC Bank.

Documents

The *Fund* is maintained pursuant to one or more *Collective Bargaining Agreements*. Copies of the agreements may be obtained by *Participant*s and beneficiaries upon written request to the *Administrative Manager* at the principal office of the *Fund*, 911 Ridgebrook Road, Sparks, Maryland 21152-9451. The *Collective Bargaining Agreements* are also available at the Bakers Confectionery, Tobacco Workers and Grain Millers International *Union* Local Nos. 118 and 68, and at each *Employer* establishment where a minimum of 50 *Participant*s who are covered under the *Fund* customarily work.

Plan Year

January 1 -- December 31

PARTICIPATING EMPLOYERS AND UNIONS

Giant Food, LLC
8301 Professional Place
Suite 115
Landover, MD 20785-2351

Safeway, Inc.
4551 Forbes Boulevard
Lanham, MD 20706

BCTGM
Local Union No. 68
Room 115
2701 W. Patapsco Avenue
Baltimore, MD 21230-2795

BCTGM
Local Union No. 118
9602-B Martin Luther King Jr. Hwy.
Lanham, MD 20706

BOARD OF TRUSTEES

UNION TRUSTEES

Al Haight
BCTGM Local 118
9602-B Martin Luther King Jr.
Hwy. Lanham, MD 20706

Gary Oskoian
BCTGM Local 68
2701 W. Patapsco Avenue
Baltimore, MD 21230

EMPLOYER TRUSTEES

David Gillis
Ahold USA
1129 Route 43 North
Aberdeen, NJ 07747

Stacey Brown
Safeway, Inc.
4551 Forbes Blvd.
Lanham, MD 20706

NOTICE: NO FUND LIABILITY

Use of the services of any *Hospital*, clinic, doctor, or other provider rendering health care, whether designated by the *Fund* or otherwise, is the voluntary act of the *Participant* or *Dependent*. Some benefits may only be obtained from providers designated by the *Fund*. This is not meant to be a recommendation or instruction to use the provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the *Fund*. Providers are independent contractors, not employees of the Plan. The *Fund* makes no representation regarding the quality of service or treatment of any provider and is not responsible for any acts of commission or omission of any provider in connection with *Fund* coverage. The provider is solely responsible for the services and treatments rendered.

NOTICE: BOARD OF TRUSTEES HAS FINAL DISCRETION

The Board of *Trustees* or any committee of the Board (collectively, the "Board") has the absolute authority to take all actions necessary to administer the *Fund*. The Board has the right to interpret and apply the rules set forth in this booklet. The Board may also make all decisions concerning the eligibility for and the amount of benefits payable under the *Fund*. The Board further has the right to resolve and clarify any ambiguities, inconsistencies and omissions which may arise under this booklet.

If the Plan Terminates

The Board intends this Plan to be in effect permanently. However, it reserves the right to amend, modify, or discontinue all or part of the *Fund* when, in its judgment, conditions warrant it. Should the Plan terminate, any remaining assets will be used first to provide benefits under the terms of the Plan to *Participant*s until all assets are exhausted. If there are any surplus assets, they will be used to provide health benefits to *Participant*s and beneficiaries in a manner determined by the *Trustees*, consistent with the provisions of the Plan and with applicable law.

DEFINITIONS

Whenever the terms below are referred to in this booklet, they should be interpreted in accordance with the following definitions.

Active Work/Actively at Work. Your attendance in-person at your usual and customary place of business (outside your residence), acting in the regular performance of the duties of your occupation for wages or profit.

***Ambulance Service*.** A licensed professional *Ambulance Service* providing local ground/surface transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

***Administrative Manager*.** The company responsible for receiving *Participating Employer* contributions, keeping eligibility records, paying claims, and providing information to you about the *Fund*. The *Administrative Manager* is Associated Administrators, LLC, and is referred to as the "*Fund Office*" throughout this booklet.

Alcoholic, Drug or Psychiatric Treatment Facility. A facility that has been approved by the Joint Commission on the Accreditation of *Hospital*s for the purpose of providing treatment for alcohol or drug abuse, or for *Mental and Nervous Disorder*s.

Ambulatory Surgical Facility. An institution that:

(1) Is established primarily for the purpose of performing surgical procedures on an outpatient basis;
(2) Maintains diagnostic and therapeutic facilities;
(3) Provides full-time services by registered professional nurses for patient care; and
(4) Is operated under the supervision of a staff of qualified *Physician*s.

***COBRA*.** Consolidated Omnibus Budget Reconciliation Act of 1985. Provides for continuation of benefits under certain circumstances for *Participant*s and their eligible *Dependent*(s) when eligibility for Plan benefits ends. .

***Collective Bargaining Agreement*.** The agreement between a *Participating Employer* and the BCTGM *Union*, Locals 68 or 118, which require contributions to the Bakers *Union* and FELRA Health and Welfare *Fund*.

***Co-Payment*.** The out-of-pocket cost a *Participant* or *Dependent* is responsible for paying when receiving benefits.

***Dependent*.** A *Dependent* includes: (a) a *Participant*'s legal spouse, (b) each of the *Participant*'s unmarried children or stepchildren (or persons for whom the *Participant* has been appointed legal guardian) from birth until his or her 19th birthday (or 23rd birthday if registered as a full-time student of an accredited educational institution and your support of your child is reflected on your federal income tax return); (c) each of the *Participant*'s unmarried children or stepchildren who reside in the United States or Canada who are incapable of self-support because of mental or physical incapacity that existed prior to reaching 19 years of age and who are wholly *Dependent* upon the *Participant* for support; and (d) any Alternate Recipient as identified in and as required by any Qualified Medical Child Support Order, but only to the extent required by such Qualified Medical Child Support Order. A *Participant* or *Dependent* may obtain a copy of the *Fund's* procedures governing Qualified Medical Child Support Orders without charge, by contacting the *Fund Office*.

Deductible

The *Deductible* is the amount you or your covered *Dependent* must pay "out of pocket" before benefits will begin to be paid under the Major Medical coverage of the Plan. The amount of the *Deductible* is shown in the Schedule of Benefits.

***Employer*.**
A signatory to a *Collective Bargaining Agreement* with a *Local Union* that requires contributions to the *Fund*.

***Experimental Treatment*.** A drug, device, medical treatment, or procedure is considered *experimental* or investigative unless:

1. Approved by the U.S. Food and Drug Administration prior to the time the drug or device is furnished;
2. The drug, device, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, medical treatment, or procedure, was reviewed and approved by the treating facility's institutional review board or other such body serving a similar function, if federal law requires such review or approval;
3. Reliable evidence shows that the drug, device, medical treatment, or procedure is not the subject of on-going Phase I or Phase II clinical trials, or the research, experimental study, or investigational arm of ongoing Phase III clinical trials, or is not otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in authoritative medical and scientific literature; the written protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent document used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

The term "*Experimental Treatment*" shall not include an Approved Clinical Trial.

Fund. The Bakers *Union* and FELRA Health and Welfare Fund.

Home Health Care. The following services provided at the patient's home under a *Physician*-approved plan of treatment when the necessary services are rendered through a certified home health care agency: part-time professional nursing; part-time home health aide services (up to four hours of such care is equal to one home health care visit); physical, occupational or speech therapy; medical supplies; drugs and medicines prescribed by a *Physician*; and necessary laboratory services.

***Hospice Care*.** Services provided at home, in a free-standing hospice facility or by a hospice team in a *Hospital* for the terminally ill where there is a medical prognosis of six months or fewer to live, or the patient is in the final stages of an incurable *Illness*.

***Hospital*.** An institution that:

1. Is engaged primarily in medical care and treatment of sick and injured persons on an inpatient basis and maintains diagnosis and therapeutic facilities for surgical and medical diagnosis and treatment of such person by or under supervision of qualified *Physician*s;
2. Continuously provides twenty-four hours a day nursing service by or under the supervision of registered graduate nurses and is operated continuously with facilities for operative surgery; and
3. Is not, other than incidentally, a place of rest, a place for the aged, or a nursing home.

***Illness*.** A disease, disorder or condition that requires treatment by a *Physician*.

***Injury*.** Damage to the body that requires treatment by a *Physician*.

***Local Union*.** Any *Local Union* affiliated with the *Union*.

***Maximum Allowable Charge*.** The *Maximum Allowable Charge* for any supply or service shall be the lesser of: a) the Cigna HealthCare allowed amount or b) an amount stipulated by the Board as the maximum allowable or reasonable charge for that service or supply; and c) the amount normally charged by a selected segment of *Physician*s or other providers in that geographic area (such segment and area as defined by the Board).

Medically Necessary. Services or supplies furnished, prescribed or ordered by a *Physician* to identify or treat an *Illness* or *Injury*, the furnishing of which is consistent with the diagnosis and treatment of the patient's condition in accordance with standards of good medical practice. That service or supply must be required for reasons other than the convenience of the patient or *Physician* and must be the most appropriate level of service or supply that can be provided safely for the patient. When the term Medically Necessary is used to describe inpatient care in a *Hospital*, it means that the patient's medical symptoms and condition are such that the service or supply cannot be provided safely to the patient on an outpatient basis. The fact that services or supplies are furnished or prescribed by a *Physician* does not necessarily mean that the services and supplies are Medically Necessary. The Board in its sole discretion shall determine whether services and supplies are Medically Necessary.

Mental and Nervous Disorder. Neurosis, psychoneurosis, psychopathy, psychosis, or other emotional manifestation of any disease or disorder whether its cause is emotional, psychological or physical.

***Minimum Work Requirement*.** The *Minimum Work Requirement* is a specified number of hours per calendar month for which

contributions are made to the *Fund* as specified in the applicable *Collective Bargaining Agreement* (or other written agreement, if applicable). The *Fund* uses the hours worked in your *Employer*'s four or five payroll periods ending in a calendar month to determine whether the *Minimum Work Requirement* is met. Work for more than one Contributing *Employer* may be combined to satisfy the *Minimum Work Requirement*.

***Miscellaneous Hospital Charges*.** The actual charges made by a *Hospital* on its own behalf for services and supplies rendered to the individual, and required for treatment of such person, the professional services of any *Physician*, and special nursing services (other than private duty nursing). *Room and Board Charges* are paid separately; they are not included under *Miscellaneous Hospital Charges*.

***Participant*.** An Employee who has met the requirements listed in the Eligibility section to be eligible for benefits from the *Fund*, and whose eligibility for benefits has not terminated. When this Summary Plan Description uses the term "You," it means a *Participant*(s).

***Physician*.** A duly licensed medical doctor (M.D.), acting within the scope of his or her license, or certain duly licensed practitioners performing services that would be payable under the *Fund* if performed by a medical doctor. The *Fund Office* will provide you, upon request, a list of licensed practitioners.

Room and Board Charges. All charges for room, board, general duty nursing, and any other charges by whatever name such charges are called, which are made by the *Hospital* as a condition of occupancy of the class of accommodations occupied. Charges for the professional services of *Physician*s are paid separately; they are not included as *Room and Board Charges*.

Totally Disabled* or *Total Disability. The condition of a person who has incurred an *Injury* or is suffering from an *Illness* that

prevents that person from engaging in any occupation or employment for remuneration or profit, as determined by the Board in its sole discretion.

Trustees. Members of the Board of *Trustees* of the Bakers Union and FELRA Health and Welfare Fund.

***Union*.** The Bakery, Confectionery, Tobacco Workers, and Grain Millers International Union AFL-CIO, Locals 68 and 118.

REQUIRED NOTICES AND POLICIES

Continuation of Coverage under the Consolidated Omnibus Budget
Reconciliation Act of 1985 (“COBRA”)

Continuation of Coverage under the Family and Medical Leave Act (“FMLA”)

Continuation of Coverage under the Uniformed Services Employment And Re-Employment Act of 1994 (“USERRA”)

Medicaid and The Children’s Health Insur. Program (“CHIP”)

Newborns’ and Mothers Health Protection Act

Women’s Health and Cancer Rights Act (“WHCRA”)

CONTINUATION OF COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 ("*COBRA*")

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("*COBRA*") provides that if an individual experiences what is known as a "Qualifying Event," which would otherwise result in a loss of health care coverage, he or she may continue their coverage for a limited period of time, in accordance with the requirements described below.

Eligible *Participant*s who experience an increase in premiums or who lose eligibility for themselves or their *Dependent*s for either of the following reasons may continue coverage for up to 18 months at his/her own expense:

1. Termination of employment (except for gross misconduct)
2. Reduction in hours of employment

The *Dependent* spouse of an eligible *Participant* may continue coverage at his/her own expense if he or she experiences an increase in premiums or loses coverage under the Plan for any of the following reasons:

1. The death of the *Participant*
2. Termination of the *Participant*'s employment (other than for gross misconduct) or reduction in the *Participant*'s hours of employment
3. Divorce or legal separation from the *Participant*, or
4. The *Participant* becomes entitled to Medicare.

The *Dependent* child of an eligible *Participant* may continue coverage at his/her own expense if he or she loses coverage under the Plan or experiences an increase in premiums for any of the following reasons:

1. The death of the *Participant*
2. Termination of the *Participant*'s employment (other than for gross misconduct) or reduction in the *Participant*'s hours of employment
3. Divorce or legal separation of the *Participant*

4. The *Participant* becomes eligible for Medicare, or
5. The *Dependent* child ceases to satisfy the *Fund's* eligibility rules.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filled with respect to the *Employer* for whom a retiree worked while covered as an active employee under the *Fund* and that bankruptcy results in the loss of retiree health coverage under the *Fund*, the retiree will become a qualified beneficiary with respect to the bankruptcy. The retiree's spouse, surviving spouse, and *Dependent* children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the *Fund*.

***Employer*'s Responsibility**

The *Participating Employer* must notify the *Fund* in writing, within 30 days of the *Participant*'s death, termination of the *Participant*'s employment, reduction in working hours, the *Participant*'s entitlement to Medicare, or the *Participating Employer*'s initiation of bankruptcy proceedings. The *Participating Employer*'s failure to provide timely notice may subject the *Participating Employer* to federal excise taxes.

***Participant*'s Responsibility**

The *Participant* or eligible *Dependent* must inform the *Fund*, in writing, within 60 days of a divorce or legal separation, or a *Dependent* child's loss of *Dependent* status under the *Fund*. The *Participant* or eligible *Dependent* who is determined to have been disabled at any time during the first 60 days of continuation coverage must notify the *Fund Office* within 60 days of the date that the Social Security Administration determines that he or she is disabled and within 30 days of any final determination that he or she is no longer disabled. If the *Participant* or eligible *Dependent* fails to notify the *Fund Office* within 60 days of the date that coverage would otherwise cease, the right to elect *COBRA* continuation coverage will be forfeited.

If you become eligible for *COBRA* Continuation Coverage, the 18-month coverage period may be extended for your spouse or beneficiaries for an additional 18 months if a second Qualifying Event occurs within the 18-month period of *COBRA* Continuation Coverage. However, in no event will *COBRA* Continuation Coverage extend beyond 36 months. Such second Qualifying Events include the death of the *Participant*, divorce or separation from the *Participant*, the *Participant*'s becoming entitled to Medicare benefits (under Part A, Part B, or both), or a *Dependent* child's ceasing to be eligible for coverage as a *Dependent* under the *Fund*. However, these events are second Qualifying Events only if they would have caused the qualified beneficiary to lose coverage under the *Fund* if the first Qualifying Event had not occurred. You must notify the *Fund Office* in writing and in accordance with the notification procedures described below in order to extend the period of continuing coverage.

All notifications under *COBRA* must comply with these provisions. Both the *Participant* and the affected *Dependent* are jointly responsible for this notice. Notice should be mailed or hand delivered to the Fund Office, Attention: COBRA Department, Bakers *Union* and FELRA Health and Welfare Fund, 911 Ridgebrook Road, Sparks, MD, 21152-9451.

The written notice of a Qualifying Event must include the following information: name and address of affected *Participant* and/or beneficiary, *Participant*'s Social Security number, date of occurrence of the Qualifying Event, and the nature of the Qualifying Event. In addition, you must enclose evidence of the occurrence of the Qualifying Event (for example, a copy of the divorce decree, separation agreement, death certificate, or *Dependent*'s birth certificate). Once the *Fund* receives timely notification that a Qualifying Event has occurred, *COBRA* coverage will be offered to the *Participant* and *Dependent*s, as applicable.

*Participant*s and beneficiaries covered under *COBRA* Continuation Coverage must provide notice of a second Qualifying Event or Disability to the *Fund* within 60 days of the date of occurrence of the second Qualifying Event or the date of disability determination, and before the end of the 18-month *COBRA* Continuation Coverage period. The written notice must conform to the requirements for providing notices described above. The notice must include evidence of the second Qualifying Event or disability (for example a copy of the divorce decree, separation agreement, death certificate, Medicare eligibility/enrollment, *Dependent*'s birth certificate, or Social Security Administration disability determination).

Failure to provide the *Fund* notice of a disability or second qualifying event within 60 days will result in the loss of the right to extend coverage.

Financial Responsibility for Failure to Give Notice

If a *Participant* or *Dependent* does not give written notice within 60 days of the date of the Qualifying Event, or a *Participating Employer* within 30 days of the Qualifying Event, and as a result, the Plan pays a claim for a person whose coverage terminated due to a Qualifying Event, then that person or the *Participating Employer*, as applicable, must reimburse the Plan for any claims that should not have been paid. If the person fails to reimburse the Plan, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the *Participant*, if the person was his or her *Dependent*.

Notification Regarding Change of Address

It is crucial that *Participant*s and beneficiaries keep the Fund informed of their current addresses. If you or a covered family member experiences a change of address, immediately inform the *Fund Office*.

Employer Participation

If your *Participating Employer* stops participating in the Plan, your continuation coverage will end on the date your *Employer* establishes a new plan, or joins an existing plan, that makes health coverage available to a class of employees formerly covered under this Plan.

Cost of *COBRA* Coverage

The cost that you must pay to continue benefits is 102% of the cost of coverage, as determined annually by the *Fund*. The cost will be specified in the notice of right to elect continuation of coverage sent to you by the *Fund Office*. However, the *COBRA* premium for the 11-month disability extension period (if applicable) is increased to 150% of the cost of coverage. If your former *Participating Employer* alters the level of benefits provided through the *Fund* to similarly situated active employees, your coverage and cost also will change.

The *Trustees* will determine the premium for the continued coverage. The premium will not necessarily be the same as the amount of the monthly contribution that a *Participating Employer* makes on behalf of a covered employee. The premium will be fixed, in advance, for a 12-month period. The *COBRA* premium will be changed at the same time every year for all *COBRA* beneficiaries, therefore, the premium may change every year for an individual beneficiary before he or she has received 12 months of *COBRA* coverage.

Trade Act Rights

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including *COBRA* continuation coverage. If you have questions about these

tax provisions, you may call Health Coverage Tax Credit Customer Contact Center toll-free 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

The federal government offers this program and the *Fund Office* has no role in its administration.

Other Rights

This notice describes your rights under *COBRA*. It is not intended to describe all of the rights available under ERISA, the Health Insurance Portability and Accountability Act (HIPAA), the Trade Act of 2002, or other laws.

Contact for Additional Information

If you have questions or wish to request additional information about *COBRA* coverage or the health plan, please contact the *Fund Office* as follows:

COBRA Department
Bakers Union & FELRA
Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
(866) 662-2537

COBRA payments can never be late. If they are, COBRA coverage is terminated.

Payment of Premiums

The initial payment must be made by you either at the time of the election or within 45 days of the election. **Ongoing payments must be made by the last day of the month for which coverage is to be continued** (for example, if you want coverage for October, payment is due no later than October 31st). If you fail to make your premium payment within 30 days of the due date, *COBRA* coverage is terminated.

You will not be billed; it is your responsibility to remit required payments to the *Fund Office*. Failure to make timely premium payments will result in termination of coverage. The *Fund Office* will not accept premiums paid on your behalf by a third party, such as a *Hospital* or any *Employer*.

Important: Your first *COBRA* payment must be made retroactively to the date of loss of eligibility.

Claims incurred following the date of the event which resulted in the loss of eligibility, but before the eligible *Participant* or *Dependent* has elected continuation coverage, will be held until the election has been made and premiums have been paid in full. If the *Participant* or eligible *Dependent* does not make a timely election and pay the premiums, no *Fund* coverage will be provided. Coverage under this Plan will remain in effect only while the monthly premiums are paid fully and on time.

CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 ("*FMLA*") requires *Participating Employers* with 50 or more employees to provide eligible employees with up to 12 weeks per year of unpaid leave in the case of the birth, adoption or foster care of an employee's child or for the employee to care for his/her own sickness or to care for a seriously ill child, spouse, or parent.

In compliance with the provisions of the *FMLA*, your *Participating Employer* is required to maintain pre-existing coverage under the Plan during your period of leave under the *FMLA* just as if you were actively employed. Your coverage under the *FMLA* will cease once the *Fund Office* is notified or otherwise determines that you have terminated employment, exhausted your 12 week *FMLA* leave entitlement, or do not intend to return from leave. Your coverage will also cease if your *Participating Employer* fails to maintain coverage on your behalf by making the required contribution to the *Fund*.

Once the *Fund Office* is notified or otherwise determines that you are not returning to employment following a period of *FMLA* leave, you may elect to continue your coverage under the *COBRA* continuation rules, as described in the previous section. The qualifying event entitling you to *COBRA* continuation coverage is the last day of your *FMLA* leave.

If you fail to return to covered employment following your leave, the *Fund* may recover the value of benefits it paid to maintain your health coverage during the period of *FMLA* leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition which affects you or a family member and which would normally qualify you for leave under the *FMLA*. If you fail to return from *FMLA* for impermissible reasons, the *Fund* may offset payment of outstanding medical claims incurred prior to the period of *FMLA* leave against the value of benefits paid on your behalf during the period of *FMLA* leave.

CONTINUATION OF COVERAGE UNDER USERRA

The Uniformed Services Employment and Re-Employment Rights Act of 1994 ("*USERRA*") requires that the *Fund* provide you with the right to elect continuous health coverage for you and your eligible *Dependent*s for up to 24 months, beginning on the date your absence from employment begins due to military service, including Reserve and National Guard Duty, as described below.

If you are absent from employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your eligible *Dependent*s under the provisions of *USERRA*. The period of coverage for you and your eligible *Dependent*s ends on the earlier of:

1. The end of the 24 month period beginning on the date on which your absence begins; or
2. The day after the date on which you are required but fail to apply for or return to a position of employment for which coverage under this Plan would be extended (for example, for periods of military service over 180 days, generally you must re-apply for employment within 90 days of discharge).

You may be required to pay a portion of the cost of your benefits. If your military service is considered an approved Leave of Absence, your *Participating Employer* must pay the cost of the premium for the first 12 months that you are eligible for coverage. If your military service is not considered an approved Leave of Absence, there is no charge for the cost of the premium for the first 31 days of coverage. Beyond 31 days, you must pay the cost of the coverage. The cost that you must pay to continue benefits will be determined in accordance with the provisions of the *USERRA*.

In order to qualify for continuation of coverage under *USERRA,* you must meet the following criteria:

1. You must be absent from covered employment because of your military service;

2. You must give advance notice to your *Employer*, unless such notice is not possible due to military necessity or is unreasonable given the circumstances;
3. You must be absent for five years or less, unless extended service is required as part of your initial obligation or your service is involuntarily extended (such as during a war);
4. You must apply for a job in covered employment within the requisite time period following your discharge from the military;
5. You must have received an honorable discharge or satisfactorily have completed your military service.;
6. You must notify the *Fund Office* that you wish to elect continuation coverage for yourself or your eligible *Dependent* under the provisions of *USERRA.*

If you have satisfied the Plan's eligibility requirements at the time you enter the uniformed services, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan when you return from uniformed service if you qualify for coverage under *USERRA*.

Military Personnel

*Participant*s who are retired from active military service are entitled to benefits from this Plan for themselves and their eligible *Dependent*s even though they may be provided benefits under the CHAMPUS Program. *Participant*s married to active duty military personnel are entitled to benefits from this Plan for themselves and any eligible *Dependent*s not in active military service. Notwithstanding the foregoing, benefits will be provided to *Participant*s and eligible *Dependent*s as required under federal law.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PORTABILITY PROGRAM ("CHIP")

If you turned down coverage for either yourself or your *Dependent*s when you were first eligible and, later, you or your *Dependent*s lose eligibility for financial assistance under Medicaid or the State Children's Health Insurance Program ("CHIP"), you may be able to enroll yourself or your *Dependent*s for coverage under the *Fund*. However, you must request enrollment under the *Fund* within 60 days of the date that CHIP or Medicaid assistance terminates for you or your *Dependent*.

In addition, you may be able to enroll yourself and your *Dependent*s in this Plan if you or your *Dependent*s become eligible to participate in a health insurance premium assistance program under Medicaid or CHIP. Again, you must request enrollment within 60 days of the date you or your *Dependent* becomes eligible for premium assistance through Medicaid or CHIP, in order to be covered under the *Fund*.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

In accordance with the Newborns' and Mothers' Health Protection Act, the Fund will provide coverage for newborns and mothers to remain in the *Hospital* after birth for a minimum of 48 hours for a normal, vaginal delivery and a minimum of 96 hours for a cesarean delivery.

WOMEN'S HEALTH AND CANCER RIGHTS ACT ("WHCRA")

The Women's Health and Cancer Rights Act ("WHCRA") provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, the Plan is required to provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending *Physician* and the patient. Required coverage includes:

- 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,
- prostheses, and
- treatment of physical complications of the mastectomy, including lymphedema, subject to the Plan's coverage provisions.

Payment for the services of an assistant surgeon will be considered after the principal surgeon has been paid, up to the limits established for each Class for that type of surgery.

ELIGIBILITY

Initial Eligibility (Plans 1, 2, 3, and 4)

Student Coverage Eligibility for Dental Benefits

Continued Eligibility

Loss of Eligibility

Reinstatement of Eligibility

Dependent Coverage

Enrolling New Dependents

Loss of Dependent Eligibility

Coverage for Disabled Dependents

ELIGIBILITY

Initial Eligibility

You will become eligible for benefits based upon the following:

Plan 1 Full-Time *Participant*s

- Plan 1 refers to Full-Time Local 118 *Participant*s hired **before** October 17, 2004 and to Full-Time Local 68 *Participant*s hired **before** October 31, 2004. You are eligible for Hospital, Medical/Surgical, Prescription Drug, Life Insurance, Accidental Death and Dismemberment, Accident and Sickness, Dental, and Vision. A completed enrollment form, and payroll deduction form must be completed to receive benefits.

Plan 2 Full-Time *Participant*s

- Plan 2 refers to Full-Time Local 118 *Participant*s **hired on or after** October 17, 2004 and to Full-Time Local 68 *Participant*s **hired on or after** October 31, 2004. You are eligible for Hospital, Medical/Surgical, Prescription Drug, Life Insurance, Accidental Death and Dismemberment, Accident and Sickness, Dental, and Vision. A completed enrollment form and payroll deduction form must be completed to receive benefits. If a Full-Time employee has coverage under Plan 2, Local 118 Participants **before** December 9, 2014 and Local 68 Participants **before** November 13, 2014, the *Participant* is eligible to elect Plan 1 coverage when they would otherwise be eligible for Plan 1 coverage. No other employee is eligible for snapback to Plan 1 or Plan 2.

Plan 3 -- Initial Eligibility for Full-Time *Participants*

- Effective January 1, 2015 for *Participants* who were hired as "Full-Time" employees (as defined under the *Collective Bargaining Agreement* applicable to such employment), Local 118 *Participants* **hired on or** after December 9, 2014 and Local 68 *Participants* **hired on or** after November 13, 2014, you are eligible for benefits under the Plan the first of the month following 1,200 hours of service, plus 60 days. This is subject

to the *Fund's* receipt of contributions, when contractually required, made on your behalf by your participating employer, and subject to you completing and filing with the *Fund Office* the necessary enrollment forms, including any payroll deduction forms. As long as you continue to work in Covered Employment, you will continue to be eligible for benefits under Plan 3 for a period of one calendar year from the date your coverage began. Plan 3 participants are not eligible to snap back to Plan 1 or Plan 2 and coverage does not include spouse coverage for Medical and Prescription Drug benefits.

Plan 3 -- Initial Eligibility for Part-Time *Participants*

- Effective January 1, 2015 *Participants* who were hired to work an undetermined number of hours per week and are entitled to be paid for an average of at least 28 hours per week during the first 12 months of employment ("initial measurement period"), you are eligible for Hospital, Medical and Prescription Drug benefits on the first day of the month after you have worked for 13 months. This is subject to the *Fund's* receipt of contributions, when contractually required, made on your behalf by your participating employer, and subject to you completing and filing with the *Fund Office* the necessary enrollment forms, including any payroll deduction forms. As long as you continue to work in Covered Employment, you will continue to be eligible for benefits under Plan 3 for a period of one calendar year from the date your coverage began. Plan 3 participants are not eligible to snap back to Plan 1 or Plan 2 and do not include spouse coverage for Medical and Prescription Drug benefits.

Plan 4 Part-Time *Participant*s

- Plan 4 effective January 1, 2015 refers to Part-Time *Participant*s that work an undetermined number of hours per week and were entitled to be paid for an average less than 28 hours per week during the first 12 months of employment ("initial measurement period"). You and your eligible dependents are eligible for Life Insurance, Accidental Death

and Dismemberment, Accident and Sickness, Dental, and Vision. Eligibility begins the first of the month following 18 months of employment.

When Do Contributions Begin?
Plan 1, 2, 3 and 4 Participants: Contributions will begin upon eligibility

Transferring Retail Clerks
A transferring clerk shall receive credit for all time worked for a contributing *Employer* toward any waiting period for participation in **Plan 2** of the Bakers *Union* & FELRA Health and Welfare *Fund*.

All *Participant*s (Regardless of Hire Date)
You must complete an enrollment form and return it to the *Fund Office* in order to be eligible for benefits. You may get an enrollment form from your *Employer*, your *Union* representative, or the *Fund Office*. Only eligible *Dependent*s who are properly enrolled will be covered.

If the *Fund* receives a Qualified Medical Child Support Order ("QMCSO") and a *Participant* fails to enroll a child covered under the QMCSO, the *Fund* will allow the custodial parent or state agency to complete the enrollment card. The *Fund* will accept "notices" from state governments for a QMCSO in lieu of a court-ordered QMCSO, provided they meet the requirements.

Special Note Regarding Mentally or Physically Incapacitated Minor *Participant*s and *Dependent*s
If the Board determines that a minor *Participant* or *Dependent* who is entitled to receive any benefit from the *Fund* is physically or mentally incapable of receiving such benefit and a valid release is provided, it may authorize payment of benefits to any person or institution that it determines will apply the benefit in the best interest of the *Participant* or *Dependent*. Contact the *Fund Office* for a release form.

Continued Eligibility

Once you are initially eligible, you become and remain a *Participant* as long as you are employed by a *Participating Employer* making contributions on your behalf and covered by a *Collective Bargaining Agreement* with the participating *Union*. A *Participant* is considered to be employed:

1. During periods of *Active Work,*
2. During paid vacations,
3. While on jury duty,
4. While collecting Weekly Accident and Sickness benefits (for a maximum of 10 consecutive months following the last month for which your *Employer* made a contribution on your behalf). While collecting Workers' Compensation benefits from the *Participating Employer* (for a maximum of 10 consecutive months following the l*ast mont*h for which your *Employer* made a contribution on your behalf).

Loss of Eligibility

A Participant will cease to be eligi*ble for benefits upon:*

1. Termination of employmen*t*
2. *Transf*er to a job classificat*ion not* covered under the *Collective Bargaining Agreement*
3. Layoff
4. Milita**r**y service except as provided under *USERRA* (see page 25)
5. Leave of absence
6. Unpaid vacations for which no contributions are made on your behalf
7. Absence due to *Illness* or *Injury* under the Weekly Accident & Sickness benefit which exceeds the maximum of 10 consecutive months following the last month for which your *Employer* made a contribution on your behalf. (The Weekly Accident & Sickness benefit is paid for a maximum of 26 weeks).
8. Absence due to *Illness* or *Injury* under the under Workers' Compensation which exceeds the maximum of 10 consecutive

months following the last month for which your *Employer* made a contribution on your behalf.

9. The end of the *Participating Employer*'s obligation to make contributions under the *Collective Bargaining Agreement*
10. Failure of the *Participating Employer* to make the required contributions on your behalf
11. Abuse of *Fund* benefits or failure to comply with reasonable requests by the *Fund* as determined by the Board of *Trustees*
12. Death

Date Benefits Terminate

You will cease to be a *Participant* on the date of termination of employment.

Extended Benefit for Major Medical Benefits

Major Medical benefits continue to be payable for medical expenses incurred during the twelve months following the last month in which you cease to be a *Participant*, unless your *Employer* ceases to be obligated to contribute to the *Fund*. This extension of benefits applies provided:

- The medical expenses you incur are in connection with any *Injury* or sickness for which you or a *Dependent* are *Totally Disabled* at the time you cease to be covered;
- You or a *Dependent* are continuously disabled on the date each medical expense is incurred; and
- You or a *Dependent* are not entitled to benefits under any other group policy or plan.

Reinstatement of Eligibility

- If you lose eligibility because of layoff, lack of work, or reduction in hours, and you later or subsequently again meet the *Minimum Work Requirement* within one year from the date your benefit terminated, you will be reinstated prospectively as a *Participant* on the first of the month following the first month in which you again met the *Minimum Work Requirement*. Otherwise, you must again meet the initial eligibility requirements in order for benefits to begin.

- If you lose eligibility because of a labor dispute, you will be reinstated as a *Participant* as of the date on which you return to work after recall, upon termination of the labor dispute.
- If you return to work while continuing to receive Workers' Compensation benefits and before you meet the *Minimum Work Requirement*, you will be treated as if you had met the *Minimum Work Requirement* limited to a maximum of 10 months.
- If you lose eligibility due to abuse of *Fund* benefits or refusal to comply with reasonable requests by the *Fund Office*, as determined by the Board of *Trustees*, your *Participant* status may be restored prospectively at the discretion of the Board of *Trustees*.

If loss of eligibility occurs due to termination of employment, a reduction in your hours of employment, or death, you and/or your eligible *Dependent*(s) may be entitled to continue coverage under *COBRA*, as explained on page 17. If the loss of eligibility occurs due to military service, you may be entitled to continue coverage under "*USERRA*" as explained on page 25.

Pre-Existing Exclusion Conditions

The *Fund* does not impose any general pre-existing exclusion.

DEPENDENT COVERAGE

To qualify for *Dependent* coverage under the Fund for Medical, Prescription, Dental, and Optical Benefits, a child must:

1. Meet the definition of "Child" below, and

2. Be under age 26. A child under age 26 can be married, does not have to be financially *Dependent* on you, and does not have to be a student to qualify for *Dependent* health coverage. However, a Child between the ages of 19 and 26 **will not qualify** for coverage if the Child is eligible for his/her own employment-based health coverage, including through the Child's spouse (if any).

"Child" Defined: Your biological or legally adopted child (including a child legally placed for adoption); a stepchild; a child for whom you have been appointed a legal guardian provided the child is claimed by you as a *Dependent* on your federal tax return; and a child for whom you have been designated as the responsible party under a Qualified Medical Child Support Order (QMCSO).

Coverage for a disabled Child may continue beyond age 26 provided the Child meets the eligibility requirements (other than age) in the Fund's Summary Plan Description.

Dental Coverage

Dental coverage ends at the end of the month in which your child turns age 19. If your dependent child is a full-time student, he/she can continue to receive dental coverage until age 23 ***if the Fund Office receives proof that he/she is a full-time student. A Student Certification is required.*** If your child is disabled, he/she can also receive dental coverage. The *Fund Office* must have received a Disability Certificate for Overage Dependent.

Let the Fund Office Know if Health Coverage Is Offered to Your *Dependent*

If your *Dependent* child is offered health coverage through his or her *Employer*, or through their spouse's *Employer*, it is your responsibility to let the Fund Office know. Once a *Dependent* child is offered coverage **(whether he or she accepts the coverage or not)** from an *Employer* or the spouse's *Employer*, the *Dependent* does not qualify for the Fund's medical coverage.

Spousal Coverage:

If you are legally separated from your spouse, you may continue covering him/her as your *Dependent* until the date of your divorce.

Documentation Required for *Dependent* Coverage

The Plan requires you to submit evidence of a *Dependent*'s eligibility in order to add him/her to your coverage. For spouses, this is a copy of the marriage license and for children, it is a copy of the birth certificate, adoption certificate, placement for adoption certificate, legal custody order, or QMCSO.

Qualified Medical Child Support Order

The *Fund* will provide *Dependent* coverage to a child if it is required to do so under the terms of a Qualified Medical Child Support Order ("QMCSO"). The *Fund* will provide coverage to a child under QMCSO even if the *Participant* does not have legal custody of the child and the child is not *Dependent* upon the *Participant* for support. If the *Fund* receives a QMCSO and the *Participant* does not enroll the affected child, the *Fund* will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. A copy of the *Fund's* procedures for determining whether an Order is a QMCSO can be obtained from the *Fund Office*, free of charge.

A QMCSO may require that Weekly Accident & Sickness disability benefits payable by the *Fund* be paid to satisfy child support obligations with respect to a child of a *Participant*. If the *Fund*

receives such an order and benefits are currently payable or become payable in the future while the order is in effect, the *Fund* will make payments either to the Child Support Agency or to the recipient listed in the order.

When Does *Dependent* Coverage Begin?

Your *Dependent*s are eligible on the same day as the *Participant*, provided they are properly enrolled on the enrollment form and the required proofs of eligibility are submitted (copies of marriage license, birth certificates, etc.). The *Fund Office* must also have on file completed payroll deduction forms for all Plans, except Plan 4.

Please note that Plan 3 coverage does not include spousal coverage for medical and prescription drug.

Enrolling New *Dependent*s

New *Dependent*s must be enrolled within 60 days from the date they become your *Dependent* (for example, within 60 days from the date of marriage for spouses or within 30 days from the date of birth, adoption, placement for adoption or legal custody). Coverage for new *Dependent*s will begin on the first of the month following the date of marriage, adoption, or placement for adoption. Newborns may be covered from date of birth if they are properly enrolled.

If you fail to enroll your *Dependent*(s) when he/she is first eligible, coverage will be effective on the first day of the month following the date the *Fund Office* receives the proper enrollment form, payroll deduction form, and documentation (copy of marriage license, birth or adoption certificate, or placement for adoption certificate).

Loss of *Dependent* Eligibility

Eligible *Dependent*s will continue to be eligible for benefits under this Plan for as long as the *Participant* is eligible. *Dependent* coverage will terminate when:

1. You lose your own eligibility,
2. The *Dependent* becomes eligible as a *Participant* under this Plan,
3. The *Dependent* is your spouse and becomes legally separated or divorced from you,
4. Your *Dependent* child is over age 26,
5. Upon your death, your *Dependent*(s) will continue to be eligible for benefits under the *Fund* for a period of one year from the date of your death unless, had you survived, you would have ceased to be a *Participant* or your *Dependent*s would have ceased to qualify as *Dependent*s. If your *Dependent*s are not eligible for benefits, they may qualify to continue coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act ("*COBRA*"). *COBRA* coverage is discussed on page 17 of this booklet,
6. If a *Dependent* is *Hospital*ized at the time of your death, coverage for the one year extended benefits will expire one year after the *Dependent* is released from the *Hospital*, or
7. *Dependent* eligibility may be terminated, in the sole discretion of the Board, if your *Dependent* abuses *Fund* benefits or fails to comply with reasonable requests by the *Fund*.

Coverage for Disabled *Dependent*s

Any child over age 26 who is incapable of self-support because of a physical or mental disability which began before age 26 may continue to be covered as an eligible *Dependent* for all *Dependent* benefits offered by the Plan. The child must be *Dependent* upon the *Participant* for support. You must complete a disability certificate annually and return it to the *Fund Office*.

Student Coverage

A dependent over age 19 may continue coverage for dental benefits under the Plan provided that he/she is a full-time student at an accredited school. You must complete a Student Certification Form and return it to the *Fund Office* within 60 days from the student's 19th birthday and annually thereafter in order for coverage to be continued. If you do not submit the form within 60 days from the student's 19th birthday, student coverage will be denied.

Students are eligible for dental coverage (1) to the end of the day in which they graduate, cease to be full time students, marry, or cease to be financially dependent for support or (2) to the end of the day prior to the day in which they turn age 23, whichever comes first.

If a student loses coverage (generally because he/she stops being a full- time student) and then returns to school full time, he/she may submit a new Student Certification form and Student Coverage will be reinstated on the first of the month following receipt of the form and all documentation. The student must meet all other eligibility requirements (under age 23, etc.).

If you do not complete a Student Certification form or the child is not enrolled full time in an accredited school, he/she will lose eligibility under this Plan. Contact the *Fund Office* for details about student coverage.

COST CONTAINMENT

Coordination of Benefits

Subrogation

Workers' Compensation

COORDINATION OF BENEFITS ("COB")

Coordination of Benefits, or "COB," applies when a *Participant* or *Dependent* is entitled to benefits (meaning benefits were offered, whether or not you chose to take them) under any other kind of group health plan in addition to the *Fund*. Virtually every group health plan has COB rules, which are designed to ensure that the responsible plan pays benefits. COB saves the *Fund* money by making sure other plans pay if they are responsible.

When duplicate coverage exists, the primary plan normally pays benefits according to its Schedule of Benefits, and the secondary plan pays a reduced amount. **The Fund will never pay, either as the primary or secondary plan, benefits which, when added to the benefits payable by the other plan for the same service, exceed 100% of the *Cigna HealthCare PPO allowed amount*.** The *Fund* is authorized to obtain information about benefits and services available from other plans to implement this rule.

The Following Rules Apply:
If one plan does not have a coordination of benefits rule, it will be primary. Otherwise, the plan which covers the person as an employee is the primary plan. The plan which covers the person as a *Dependent* is the secondary plan.

When the *Fund* is primary, it pays claims according to its Schedule of Benefits. If the *Fund* is secondary, it pays the balance(s) remaining after the primary has paid, but only in accordance with its own Plan rules and Schedule of Benefits. In other words, if there are exclusions or limitations under the *Fund*, they continue to apply whether the *Fund* is processing a claim as the primary payer or the secondary payer. Casualty insurance (including, without limitation, no fault automobile insurance, personal *Injury* protection, and uninsured or underinsured motorist coverage) is considered an additional plan to the extent that it provides payment of expenses which are covered under this Plan.

Note: If the *Fund* is secondary and the primary plan establishes to the satisfaction of the Board of *Trustees* that it is unable to pay a claim in question, the Plan may, at the sole discretion of the Board of *Trustees*, pay a portion or all of a claim that would have been the responsibility of the primary plan.

Determination Rules

The *Fund* will determine which plan is primary and which plan is secondary as follows:

- The plan covering the person as an employee or retiree is primary (for either the *Participant* or the *Dependent*).
- If the rule above does not determine the order of benefits, the plan that has covered the person as primary for a longer period of time is primary and the plan that has covered him/her for a shorter period of time is secondary. This rule does not apply to individual insurance policies that are specifically designed and priced to cover gaps in other medical insurance.
- If a *Dependent* who is retired is covered under this Plan and is also covered under Medicare and also under his/her former *Employer*'s retiree health and welfare plan, the *Dependent*'s retiree plan will pay as primary, Medicare pays as secondary, and this Plan pays as tertiary (third).
- Before the *Fund* will pay benefits to an employed *Dependent*, he or she must provide the *Fund Office* with information explaining his/her *Employer*'s health coverage for purpose of coordination of benefits.
- If you and your spouse are both *Participant*s in this Plan, if eligible, *Dependent* benefits will be the sum of the benefits payable under your Schedule of Benefits and your spouse's Schedule of Benefits, but in no event will the *Fund* pay more than the actual expenses incurred.
- **Plan 2 *Participant*s: If a *Participant*'s spouse is eligible for coverage where his/her *Employer* pays at least 70% of the premium, regardless of whether or not spouse takes this coverage, this Plan will provide secondary coverage <u>ONLY</u>.**

Coordination of Benefits for *Dependent* Children

Where both parents are covered by different plans, and the parents are not separated or divorced, and the claim is for a *Dependent* child, the primary plan is the plan of the parent whose birthday falls earliest in the year. If both parents have the same birthday, the plan which has covered a parent longer pays first.

If two or more plans cover a child whose parents are separated or divorced, benefits will be paid as follows:

1. If a court determines financial responsibility for a child's health care expenses, the plan of the parent having that responsibility pays first.
2. If a court determination has not been made, the plan of the parent with custody pays before the plan of the other parent. The plan of the step-parent married to the parent with custody of the child pays before the plan of the parent who does not have custody.

Medicare – Coordination of Benefits for *Participant*s Who Are Actively Working

All active *Participant*s over age 65 and spouses over age 65 of active *Participant*s of any age will be entitled to receive coverage under this Plan under the same conditions as a *Participant* or *Participant*'s spouse under age 65.

Absent an election (described below), the Plan will be the primary payor of medical costs for active *Participant*s, and spouses over age 65 of active *Participant*s of any age, with Medicare providing secondary coverage. This means you will be reimbursed first under this Plan (except in the case of End Stage Renal Disease "ESRD," as set forth below). If there are covered expenses <u>not</u> paid by the Plan, Medicare may reimburse you--if the expenses are covered by Medicare. To get reimbursement from Medicare, you must enroll for Medicare. In addition, to get coverage under Part B of Medicare, you must enroll and pay a monthly premium.

a.) Election of Medicare

If you are age 65 or older, you are still entitled to elect Medicare as your primary insurance coverage in lieu of the Plan. However, an active *Participant* over age 65 or an active *Participant*'s spouse over age 65 will automatically continue to be covered by this Plan as the primary insurer unless you (1) notify the *Fund Office*, in writing, that you do not want coverage under this Plan or 2) you cease to be eligible for coverage under this Plan. If you elect coverage under Medicare, the Plan cannot, under law, with the exception of End Stage Renal Disease (ESRD), pay benefits secondary to Medicare. If you have any questions about the coordination of benefits under this Plan with Medicare benefits, contact the *Fund Office*.

b.) Disability

If you are actively employed and you or your eligible *Dependent*(s) are under age 65 and are entitled to Medicare due to disability (other than ESRD), the Plan will pay benefits as primary.

c.) End Stage Renal Disease (ESRD)

If you or your eligible *Dependent*(s) become entitled to Medicare based on ESRD, and the Plan is currently paying benefits as primary, the Plan will remain primary for the first 30 months of your entitlement to Medicare due to ESRD to the extent required by law. If the Plan is currently paying benefits secondary to Medicare, the Plan will remain secondary upon your entitlement to Medicare due to ESRD.

Coordination of Benefits with an HMO

If you have primary coverage through your work under an HMO and secondary coverage under the *Fund* as a *Dependent* of your spouse, **you must follow the rules of the HMO in order to have remaining balances considered for payment by the Fund as secondary payer**. If you go outside of your HMO for services (or otherwise fail to follow the rules of the HMO), and then submit the bill to the *Fund* for secondary payment, the claim will be denied.

For purposes of coordinating benefits, an HMO is treated the same as any other plan. **If you fail to follow the rules of any primary plan, including an HMO, the Fund will not pay benefits as either primary or secondary.**

The *Fund* also has the right to collect any excess payment directly from the parties involved, from the other plan, **or by offset against any future benefit payment from the Fund** on the *Dependent*'s behalf, if he or she failed to notify the *Fund Office* of the availability of the other *Employer*'s health coverage. This right of offset does not keep the *Fund* from recovering erroneous payments in any other manner.

Important: To ensure that the *Fund* coordinates and pays your benefits properly, you must keep the *Fund* informed of any and all coverage for you and your eligible *Dependent*.

SUBROGATION

The *Fund* does not cover and is not responsible for medical costs or weekly Accident and Sickness benefits that are the result of injuries caused by a third party. However, as a benefit to you, the *Fund* will agree to pay such costs provided you first agree to repay the *Fund* if you recover from the third party responsible for your injuries. This is called "subrogation." Subrogation means that if the *Fund* pays benefits to you or on your behalf, and you later recover money from a third party, you must repay the *Fund*. As explained below, failure to repay the *Fund* after you recover some or all of your expenses from a third party can subject you and your *Dependent*s to temporary or permanent suspension of benefits, collection proceedings, and even litigation.

Were you or your eligible *Dependent* injured in a car accident or other type of accident in which someone else is liable? If so, that person (or his/her insurance) is responsible for paying your (or your eligible *Dependent*'s) Medical and Weekly Accident and Sickness expenses.

Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court), and your creditors will not wait patiently. Because of this, as a service to you, the *Fund* will pay you (or your eligible *Dependent*) benefits based on the understanding that **you are required to reimburse the Fund in full** from **any** recovery you or your eligible *Dependent* may receive, no matter how it is characterized. This process is called "subrogation." The *Fund* advances benefits to you and your *Dependent*s only as a service to you. You must reimburse the *Fund* if you obtain any recovery from another person or entity.

You and/or your *Dependent* are required to notify the *Fund* at the time you file your claim for any accident or *Injury* for which someone else may be liable. Further, the *Fund* must be notified within ten days of the initiation of any lawsuit arising out of the

accident and of the conclusion of any settlement, judgment or payment relating to the accident in any lawsuit.

If you or your *Dependent* receive **any** benefit payments from the *Fund* for any *Injury* or sickness, and you or your *Dependent* recover any amount from any third party or parties in connection with such *Injury* or sickness, you or your *Dependent* must reimburse the *Fund* from that recovery the total amount of all benefit payments the *Fund* made or will make on your or your *Dependent*'s behalf in connection with such *Injury* or sickness.

In addition, if you or your *Dependent* receive any benefit payments from the *Fund* for any *Injury* or sickness, the *Fund* is subrogated to all rights of recovery available to you or your *Dependent* arising out of any claim, demand, cause of action or right of recovery which has accrued, may accrue or which is asserted in connection with such *Injury* or sickness, to the extent of any and all related benefit payments made or to be made by the *Fund* on your or your *Dependent*'s behalf. This means that the *Fund* has an independent right to bring an action in connection with such *Injury* or sickness in your or your *Dependent*'s name and also has a right to intervene in any such action brought by you or your *Dependent*, including any action against an insurance carrier under any uninsured or underinsured motor vehicle policy.

The *Fund's* rights of reimbursement and subrogation apply regardless of the terms of the claim, demand right of recovery, cause of action, judgment, award, settlement compromise, insurance or order, regardless of whether the third party is found responsible or liable for the *Injury* or sickness, and regardless of whether you and your *Dependent* actually obtain the full amount of such judgment, award, settlement compromise, insurance or order. The *Fund's* right of reimbursement and subrogation provide the *Fund* with first priority to any and all recovery in connection with the *Injury* and sickness, whether such recovery is full or partial and no matter how such recovery is characterized,

why or by whom it is paid, or the type of expense for which it is specified.

Such recovery includes amounts payable under your or your *Dependent*'s own uninsured motorist insurance, under-insured motorist insurance, casualty insurance, any other insurance carriers, benefit plans, Workers' Compensation plans, or any medical pay or no-fault benefits payable. The "make-whole" doctrine does not apply to the *Fund's* right of reimbursement and subrogation. The *Fund's* rights of reimbursement and subrogation are for the full amount of all related benefits payments; this amount is not offset by legal costs, attorney's fees or other expenses incurred by you or your *Dependent* in obtaining recovery. The *Fund* shall have a lien on any amount received by you, your *Dependent* or representative of you or your *Dependent* (including an attorney) that is due to the *Fund* under this Section, and any such amount shall be deemed to be held in trust by you or your *Dependent* or your attorney for the benefit of the *Fund* until paid to the *Fund*.

Consistent with the *Fund's* rights set forth in this section, if you or your *Dependent* submit claims for or receive any benefit payments from the *Fund* for an *Injury* or sickness that may give rise to any claim against any third party, you and/or your *Dependent* will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" affirming the *Fund's* rights of reimbursement and subrogation with respect to such benefit payments and claims. This Agreement must also be executed by your or your *Dependent*'s attorney.

Because benefit payments are not payable unless you sign a Subrogation Agreement, your or your *Dependent*'s claim will not be considered filed and will not be paid if the period for filing claims passes before your fully completed Subrogation Agreement is received.

Further, the Plan excludes coverage for any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or *Hospital*ization may be covered by, or on behalf of, you or your *Dependent* in any action at law, any judgment compromise or settlement of any claims against any party, or any other payment you, your *Dependent* or your attorney may receive as a result of the accident or *Injury*, no matter how these amounts are characterized or who pays these amounts, as provided in this Section.

Under this provision, you and/or your *Dependent* are obligated to take all necessary action and cooperate fully with the *Fund* in its exercise of its rights of reimbursement and subrogation, including notifying the *Fund* of the status of any claim or legal action asserted against any party or insurance carrier and of you or your *Dependent*'s receipt of any recovery. You or your *Dependent* also must do nothing to impair or prejudice the *Fund's* rights. For example, if you or your *Dependent* choose not to pursue the liability of a third party, you or your *Dependent* may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the *Fund Office* immediately. Where you or your eligible *Dependent* choose not to pursue the liability of a third party, the acceptance of benefits from the *Fund* authorizes the *Fund* to litigate or settle your claims against the third party. If the *Fund* takes legal action to recover what it has paid, the acceptance of benefits obligates you and your *Dependent* (and your attorney if you have one) to cooperate with the *Fund* in seeking its recovery, and in providing relevant information with respect to the accident.

You or your *Dependent* must also notify the *Fund* before accepting any payment prior to the initiation of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the *Fund* has advanced you, you will still be required to repay the *Fund*, in full, for any benefits it has paid. The *Fund* may withhold benefits if you or your *Dependent* waive any of the

Fund's rights to recovery or fail to cooperate with the *Fund* in any respect regarding the *Fund's* subrogation rights.

If you or your *Dependent* refuse to reimburse the *Fund* from any recovery or refuse to cooperate with the *Fund* regarding its subrogation or reimbursement rights, the *Fund* has the right to recover the full amount of all benefits paid by methods which include, but are not necessarily limited to, temporary or permanent suspension of benefits, and/or offsetting the amounts paid against your future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation, Assignment of Rights, and Reimbursement Agreement and the failure of any party to respond to the *Fund's* inquiries concerning the status of any claim or any other inquiry relating to the *Fund's* rights of reimbursement and subrogation.

WORKERS' COMPENSATION

If you were injured at work or as a result of your work, generally the claim(s) are paid through your *Employer*'s Workers' Compensation carrier. However, if the carrier denies your claim(s), the *Fund* may pay them, provided you follow the steps below.

1. First, you must file a report of *Injury* or *Illness* with your *Employer*, as well as a Workers' Compensation ("WC") claim. **At the same time, file a claim(s) with the *Fund Office*.** The *Fund Office* will deny your claim pending a decision from Workers' Compensation, but you have protected yourself by filing on time with the *Fund*.

2. If the Workers' Compensation carrier approves your claim, it will pay the claims related to that *Injury*/*Illness*. You should send a copy of the WC approval letter to the *Fund Office*. The *Fund Office* takes no further action.

3. If the WC carrier denies your claim ***as being non-compensable under Workers' Compensation law***, you must pursue a claim with the Workers' Compensation Commission ("WC Commission") and attend the Workers' Compensation hearing.

4. The *Fund Office* will send you what is called an "indemnity agreement." If you sign and return the agreement, the *Fund* will process and pay your ***Weekly Accident and Sickness*** claim(s) pending the decision of the WC Commission. **Medical claims related to the *Injury*/*Illness* will not be processed until the final decision from the WC Commission is rendered.**

5. If you pursue a claim with the WC Commission and your claim is approved (meaning your *Injury* or *Illness* had been determined to be work-related), the Workers' Compensation carrier will pay your claim(s). You must send a copy of the WC

award letter to the *Fund Office*. The *Fund Office* will request a refund of any Weekly Accident & Sickness benefits it has paid (if any). The *Fund Office* will mail the *Participant* three notices requesting repayment in 15-day intervals. If the *Fund Office* receives repayment, no further action is taken. If the *Participant* fails to repay the *Fund Office* after the third notice, the *Participant*'s benefits will be suspended, and a notice stating this will be sent to the *Participant*. Benefits will be reinstated after you repay the *Fund* in full or the Board of *Trustees* determines that your benefits should be reinstated.

6. If the WC Commission denies your claim (meaning it upholds the original denial), you must send a copy of the denial to the *Fund Office* along with a letter stating that you do not intend to appeal the Commission's decision. Once the *Fund Office* has received both a copy of the Commission's denial and your letter stating that you do not intend to appeal the denial, your medical claim(s) relating to the *Illness* or *Injury* will be processed, and you may keep the Weekly Accident and Sickness benefits paid to you.

YOUR BENEFITS

SUMMARY OF BENEFITS FOR <u>FULL-TIME PLAN 1 PARTICIPANTS</u>

Accidental Death and Dismemberment *Participant Only*	$20,000. Benefits provided through Voya Financial.
Accident and Sickness *Participant Only*	$200 per week for a maximum of 26 weeks. Eligibility for all benefits continues during sick pay.
Deductible	Major Medical: $300 person/$600 family. Does not apply to prescription drugs, dental, vision, some preventive care, and "Basic Benefits."
Dental *Participant and Eligible Dependent(s)*	$50 per person/$150 per family dental deductible. Benefits provided through Denex Dental.
Life Insurance *Participant Only*	$20,000. Benefits provided through Voya Financial.
Medical Services	80% up to the Cigna allowed amount, with deductible to the out-of-pocket maximum. Cigna Shared Administration Network mandatory or no benefits will be paid with limited exception.

Mental Health/ Substance Abuse	**<u>Outpatient</u>** Mental/Behavioral Health or Substance Use Disorder Services when you use an in-network provider: you pay 20% co-insurance, after deductible, for the first two visits per year. **<u>Inpatient</u>** Mental/Behavioral Health or Substance Use Disorder Services when you use an in-network provider: You pay $0 up to 70 days in a semi-private room, then 20% co-insurance after the deductible. **Certify all mental health/substance abuse care through CareAllies.**
Optical *Participant and Eligible Dependent(s)*	Exam and glasses every two years provided through Vision Service Plan (VSP).
Out-of-Pocket Maximum	Medical: $4,000 per person/$8,000 per family. Prescription Drug: $2,850 per person/$5,700 per family.
Preventive Care	Covered at 100% for in-network providers. See page 77 for list of covered services.
Prescription Drug *Participant and Eligible Dependent(s)*	$10 per prescription co-pay for generic drugs; $15 for brand name drugs on Optum's formulary list, and $30 for brand name drugs not on Optum's formulary list. Co-pays double for maintenance drugs or drugs ordered through mail order (i.e., a 90-day supply).

SUMMARY OF BENEFITS FOR <u>FULL-TIME PLAN 2 PARTICIPANTS</u>

Accidental Death and Dismemberment *Participant Only*	$20,000. Benefits provided through Voya Financial.
Accident and Sickness *Participant Only*	$200 per week for a maximum of 26 weeks. Eligibility for all benefits continues during sick pay.
Deductible	Major Medical: $300 person/$600 family. Does not apply to prescription drugs, dental, vision, some preventive care, and "Basic Benefits."
Dental *Participant and Eligible Dependent(s)*	$50 per person/$150 per family dental deductible. Benefits provided through Denex Dental.
Life Insurance *Participant Only*	$20,000. Benefits provided through Voya Financial.
Medical Services	75% up to the Cigna allowed amount, with deductible to the out-of-pocket maximum. Cigna Shared Administration Network mandatory or no benefits will be paid with limited exception.
Mental Health/ Substance Abuse	**<u>Outpatient</u>** Mental/Behavioral Health or Substance Use Disorder Services when you use an in-network provider: you pay 20% co-insurance, after deductible, for the first two visits per year. **<u>Inpatient</u>** Mental/Behavioral Health or Substance Use Disorder Services when you use an in-network provider: You pay $0 up to 70 days in a semi-private room, then 20% co-insurance after the deductible. **Certify all mental health/substance abuse care through CareAllies.**

Optical *Participant and Eligible Dependent(s)*	Exam and glasses every two years provided through Vision Service Plan (VSP).
Out-of-Pocket Maximum	Medical: $5,000 per person/$10,000 per family. Prescription Drug: $1,850 per person/$3,700 per family.
Preventive Care	Covered at 100% for in-network providers. See page 77 for list of covered services.
Prescription Drug *Participant and Eligible Dependent(s)*	$10 per prescription co-pay for generic drugs; $15 for brand name drugs on Optum formulary list, and $30 for brand name drugs not on Optum's formulary list. Co-pays double for maintenance drugs or drugs ordered through mail order (i.e., a 90-day supply).

SUMMARY OF BENEFITS FOR <u>FULL-TIME AND PART-TIME</u> <u>PLAN 3 PARTICIPANTS</u>

Accidental Death and Dismemberment *Participant Only*	$20,000. Benefits provided through Voya Financial.
Accident and Sickness *Participant Only*	$200 per week for a maximum of 26 weeks. Eligibility for all benefits continues during sick pay.
Deductible	Major Medical: $500 per covered individual per year. Does not apply to prescription drugs, dental, vision, some preventive care, and "Basic Benefits."
Dental *Participant and Eligible Dependent(s). Excludes Spouse.*	$50 per person/$150 per family dental deductible. Benefits provided through Denex Dental.
Emergency Room	$75 per visit co-pay; waived if admitted to the *Hospital*.
Life Insurance *Participant Only*	$20,000. Benefits provided through Voya Financial.
Medical Services *Participant and Eligible Dependent(s). Excludes Spouse.*	70% up to the Cigna allowed amount, with deductible to the out-of-pocket maximum. Cigna Shared Administration Network mandatory or no benefits will be paid with limited exception.
Mental Health/ Substance Abuse	**<u>Outpatient:</u>** Mental/Behavioral Health or Substance Use Disorder Services when you use an in-network provider: you pay 20% co-insurance, after deductible, for the first two visits per year. **<u>Inpatient:</u>** Mental/Behavioral Health or Substance Use Disorder Services when you use an in-network provider: You pay $0 up to 70 days in a semi-private room,

	then 20% co-insurance after the deductible. **Certify all mental health/substance abuse care through CareAllies.**
Optical *Participant and Eligible Dependent(s)*	Exam and glasses every two years provided through Vision Service Plan (VSP).
Out-of-Pocket Maximum Per Year	Medical: $5,000 per person/$10,000 per family. Prescription Drug: $1,850 per person/$3,700 per family.
Preventive Care	Covered at 100% for in-network providers. See page 77 for list of covered services.
Prescription Drug *Participant and Eligible Dependent(s)*	5% co-pay (with a $5 minimum) for generic drugs; 15% co-payment (with a $15 minimum) for brand name drugs on the preferred formulary list; 25% co-payment (with a $25 minimum) for brand name drugs not on the preferred formulary list. Benefits provided through OptumRx. Certain drugs must be on the OptumRx formulary list in order to be covered. If a prescription for a drug from those categories which is not on the formulary list is presented at the pharmacy, alternate options will be given to you and a script for one of the alternate drugs must be presented in order to be covered. Generics **mandatory** if available (brand name not covered).

SUMMARY OF BENEFITS FOR <u>PART-TIME PLAN 4 PARTICIPANTS</u>

Accidental Death and Dismemberment *Participant Only*	$20,000. Benefits provided through Voya Financial.
Accident and Sickness *Participant Only*	$200 per week for a maximum of 26 weeks. Eligibility for all benefits continues during sick pay.
Dental *Participant and Eligible Dependent(s)*	$50 per person/$150 per family dental deductible. Benefits provided through Denex Dental.
Life Insurance *Participant Only*	$20,000. Benefits provided through Voya Financial.
Optical *Participant and Eligible Dependent(s)*	Exam and glasses every two years provided through Vision Service Plan (VSP).

LIFE BENEFIT

Insured by Voya Financial
20 Washington Avenue South
Minneapolis, MN 55401

***Participant* Only**

In the event of your death while insured, $20,000 is payable to the person you have named as your beneficiary.

The beneficiary for Life Insurance and for the Accidental Death portion of Accidental Death and Dismemberment Insurance is the most recent designation made by the *Participant* as shown on file with the *Fund Office*. In accordance with the terms of the Group Policy, the *Participant* may change his/her beneficiary at any time by notifying the insurance company through the *Fund Office*.

Beneficiary

You may name any person you choose to be your beneficiary. You may change the named beneficiary at any time.

1. Contact the *Fund Office* for an enrollment form.
2. Complete and sign the form.
3. Return the form to the *Fund Office*.

Only enrollment forms which are properly completed, signed, and received by the *Fund Office* prior to a *Participant*'s death will be honored.

A beneficiary may be designated in an entered court order, provided that such order contains a clear designation of rights. The designation in a court order will only be effective when it reaches the *Fund Office* and provided that the *Fund* has not made payment or taken other action before the designation was received. A beneficiary designation in a court order that meets these requirements will supercede any prior or subsequent conflicting beneficiary designation that is filed with the *Fund Office*.

The **beneficiary** is named to receive the proceeds to be paid at your death. You may name one or more beneficiaries. You cannot name the Policyholder as beneficiary.

You may name, add, or change beneficiaries by written request as described below. You may also choose to name a beneficiary that you cannot change without his or her consent. This is an **irrevocable beneficiary.**

How do you name, add, or change beneficiaries?
You can name, add, or change beneficiaries by written request if all of these are true:
- Your coverage is in force.
- We have written consent of all irrevocable beneficiaries.
- You have not assigned the ownership of your insurance. The rights of an assignee are described under the Assignment section.

All requests are subject to our approval. A change will take effect as of the date it is signed but will not affect any payment we make or action we take before receiving your notice.

To whom do we pay proceeds?
We pay proceeds to the beneficiary. If there is more than one beneficiary, each receives an equal share, unless you have requested another method in writing. To receive proceeds, a beneficiary must be living on the earlier of the following dates:
- The date we receive proof of your death.
- The 10th day after your death.

If there is no eligible beneficiary or if you did not name one, we pay proceeds to the persons listed below in order. The person must be living on the tenth day after your death:
1. Your spouse.
2. Your natural and adopted children.
3. Your parents.
4. Your estate.

Accelerated Death Benefit
This benefit allows 50% of the amount of your Life Insurance in force (or $10,000, whichever is less) to be paid to you or your legal representative if it has been determined that you have a terminal condition and your life expectancy is less than six months. The Accelerated Death Benefit is paid in one lump sum, one time only. You or your legal representative must request this benefit in writing while you are still living.

The Accelerated Death Benefit is paid **in lieu of** your full Death Benefit. If you received an Accelerated Death Benefit, your life insurance benefit is reduced by the Accelerated Death Benefit proceeds paid out under this provision. There are conditions you must meet in order to be eligible for the Accelerated Death Benefit. If you wish to get more information and the necessary forms, contact the *Fund Office* and we will assist you.

Voya Financial ("Voya") will not pay any Accelerated Death Benefit for a terminal condition if it is determined that the condition is directly or indirectly caused by attempted suicide or intentionally self-inflicted *Injury*, whether you are deemed sane or insane at the time of the *Injury*.

Waiver of Premium
If you become *Totally Disabled* and unable to work while you are covered under this Plan and before your 60th birthday, your Life Benefit and Accelerated Death Benefit will remain in effect and any premiums due will be waived while your *Total Disability* is in effect. This provision is called "Waiver of Premium." Accidental Death and Dismemberment benefits do not continue if you are covered under a Waiver of Premium status. You must send the *Fund Office* a written notice within one year from the date you became *Totally Disabled* (or as soon as reasonably possible under your circumstances). Contact the *Fund Office* for the Waiver of Premium forms. We will send the notice to Voya for review. In order to approve a waiver of premium, Voya must receive proof of your

Total Disability. Voya has the right to require you to have an annual physical exam by a doctor of its choice before approving the Waiver of Premium. Voya may require only one exam a year after premiums have been waived for two full years. Voya pays for all exams it requires.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Insured by Voya Financial
20 Washington Avenue South
Minneapolis, MN 55401

***Participant* Only**

This benefit is payable if you suffer any of the losses below as a result of and within 180 days from the date of an accident occurring while insured.

For Loss of:	**Benefit Amount is as stated in the "Schedule of Benefits"**
Life	Full Amount Paid to Your Beneficiary.
Both Hands or Both Feet or Sight of Both Eyes	Full Amount Paid to You.
Any Combination of Foot, Hand, or Sight of One Eye	Full Amount Paid to You.
One Hand, One Foot, or Sight of One Eye	Half of the Full Amount Paid to You.

Benefits for the insured during all periods of coverage under the policy will be paid for no more than one loss for which the full amount is payable, nor for more than two losses for which half the amount is payable.

The benefit for Accidental Death is in addition to the Life Insurance benefit.

Accidental Death & Dismemberment Exclusions

Accidental Death & Dismemberment benefits will not be paid for losses directly or indirectly caused by any of the following:

- Suicide or intentionally self-inflicted *Injury*, whether you are deemed sane or insane.
- Physical or mental *Illness*
- Bacterial infection. Exception: Infection from a cut or wound caused by an accident is covered.
- Riding in or descending from an aircraft as a pilot or crew member
- Any armed conflict, whether declared as war or not, involving any country or government.
- *Injury* suffered while in the military service of any country or government.
- *Injury* which occurs when you commit or attempt to commit a felony.
- Voluntary use of any drug, narcotic, or hallucinogenic agent unless prescribed by a doctor (such use is illegal); or use of any drug, narcotic, or hallucinogenic that does not comply with the directions given by a doctor or the manufacturer.

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Benefits are not paid for loss of use of a hand or foot.

Beneficiary Designation

A beneficiary may be designated in an entered court order, provided that such order contains a clear designation of rights. The designation in a court order will only be effective when it reaches the *Fund Office* and provided that the *Fund* has not made payment or taken other action before the designation was received. A beneficiary designation in a court order that meets these requirements will supercede any prior or subsequent conflicting beneficiary designation that is filed with the *Fund Office*.

A beneficiary who has been named in a court order as described above may waive his/her rights, provide the court order contains a clear waiver of rights. If this occurs and the beneficiary waives his/her rights, and you die without naming a new beneficiary, the *Fund* will pay the death benefit in the following order:

1. Your surviving spouse.
2. Your surviving natural and adopted children
3. Your surviving parents.
4. Your estate.

Group Policy Information

The group policy has been issued to the Bakers Union and FELRA Health and Welfare Fund. The group policy is on file and may be examined at the *Fund Office*. **The policy number is 61532-3GAT.**

This is a description of the insurance issued under, and subject to the terms, conditions, and provisions of the group policy. The group policy controls in all instances. This section merely summarizes and explains the pertinent provisions of the group policy, and it does not constitute a contract of insurance.

Life Conversion Privilege (Upon Termination of Coverage)

If your insurance is terminated because of loss of eligibility, you may convert your group life insurance without medical examination or other evidence of insurability to any life insurance policy then customarily issued by Voya Financial ("Voya"), except term insurance, by applying to Voya at this address:

Voya Financial
20 Washington Avenue South
Minneapolis, MN 55401

You may convert within 31 days after loss of eligibility and you will pay the premium applicable:

- To the form and amount of the policy at your age; and
- To the amount you select, up to the amount for which you were insured under the Plan.

If your insurance is terminated due to discontinuance of the Plan, you have the same conversion privilege if insured under this Plan for five years or longer, except that the amount of life insurance will be reduced by the amount of any life insurance you are eligible for under any new plan within 31 days of termination or $20,000, whichever is less. Your group life insurance is payable if you die within the 31 day period allowed for conversion whether or not you have applied for an individual policy.

Life and AD&D Claims Procedure

To file a claim for Life Insurance benefits or for Accidental Death and Dismemberment ("AD&D") benefits, you must send a copy of the death certificate to the *Fund Office*, or, in the case of dismemberment, proof of loss. For Accidental Death, you must submit evidence that the death was an accident along with the copy of the death certificate.

Claims for Life and AD&D benefits must be submitted within 20 days from the date on which the claim occurred or as soon thereafter as reasonably possible.

For more information about filing or appealing a claim, see "Claims Filing and Review Procedure" on page 146.

WEEKLY ACCIDENT & SICKNESS BENEFIT

Benefits are provided through the *Fund*, not insured.
Benefit claims are processed by Associated Administrators, LLC

***Participant* Only**

Weekly Accident & Sickness Benefits (commonly referred to as "Weekly A&S" or just "A&S" benefits) are paid directly from the *Fund's* assets to an eligible *Participant* who is *Actively at Work* and becomes disabled to the extent that he or she cannot perform any of the usual and customary duties with a *Participating Employer*. In order to be eligible for Weekly A&S, you must meet the following requirements:

1. You must submit a completed initial claim form (one which has been approved by the Board of *Trustees*) within 2 years (24 months) from the date your disability began. Continuation forms are sent every six weeks to verify your continuing disability, and must be returned within four weeks from the date sent by the *Fund Office*. If you fail to return a completed continuation form on time, no further Weekly A&S benefits will be paid for that disability.
2. The disability must be verified in writing on your claim form by a *Physician* legally licensed to practice medicine. You must be seen **in-person** by a *Physician*—telephone consultations do not satisfy this requirement.
3. All questions on the claim form must be answered—incomplete forms will be returned for completion. We may not accept copies or faxes of your original claim form.
4. No disability will be considered as beginning until after your last day worked.
5. Requests for additional information from the *Fund* must be returned within two weeks from the date mailed by the *Fund*.
6. The fact that a claim for benefits from a source other than the *Fund* is pending (for example, Workers' Compensation or automobile insurance) does not excuse these reporting requirements.

7. Benefits are not payable if the *Injury* or *Illness* is:
   - Compensable under Workers' Compensation legislation, occupational disease act legislation, *Employer*'s liability laws or other similar legislation, or your Personal *Injury* Protection ("PIP") insurance for lost wages;
   - Caused by war or an act of war
   - Intentionally Self-inflicted
   - The responsibility of some other person or entity
   - Sustained while in the commission of a felony or willful misconduct.
   - Benefits will not be paid for days used as vacation days or other paid time by the *Participating Employer*, except for sick leave provisions in the *Collective Bargaining Agreements*.
8. Successive periods of disability due to the same or related causes shall be considered as one period of disability unless they are separated by at least one week of *Active Work*.
9. The *Fund* reserves the right and opportunity to examine the person whose *Injury* or *Illness* is the basis of a claim as often as reasonably required during the pendency of a claim.
10. Lack of knowledge of coverage does not excuse these requirements.
11. If the *Fund* receives a QMCSO (Qualified Medical Child Support Order) directing that Weekly Accident & Sickness benefits be paid to satisfy a *Participant*'s child support obligations, and benefits are currently payable or become payable while the QMCSO is in effect, the *Fund* will make payment to either the state agency or the alternate payee listed in the QMCSO.
12. You must be receiving treatment from a *Physician* to <u>improve</u> the condition which is causing your disability.

Benefit Amount for Plans 1, 2, 3 and 4 *Participant*s

The Weekly Accident and Sickness benefit is $200.00 per week for a maximum of 26 weeks.

Benefits begin on the first day of disability if the disability is due to an accident which immediately disables you from working.

Benefits begin on the eighth day of disability if it is because of sickness.

You may receive Weekly A&S benefits for a maximum of 26 weeks. Periods of disability separated by **less than one week's** return to full-time work are considered as one period of disability when counting the maximum benefit time ***unless*** the second disability is a result of completely unrelated causes and one which begins after your return to *Active Work*.

Benefit Exhaustion

Your eligibility status for other benefits will be maintained while you are receiving Weekly A&S benefits (Weekly A&S benefits continue for a maximum of 26 weeks). However, if you are absent from work due to an *Illness* or *Injury* under Weekly A&S for more than ten consecutive months following the last month in which your *Employer* made a contribution on your behalf for at least 96 hours worked, benefits will cease. If you secure a leave of absence from your *Participating Employer*, benefits may be continued under the provisions of *COBRA* as described on page 17.

Claims Procedure

To claim a benefit from the *Fund*, you must:

1. Get a Weekly Accident and Sickness Claim Form from the *Fund Office*.
2. Complete the *Participant* section of the form and sign it.
3. Have your *Physician* complete the *Physician* section of the form and sign it.
4. Corrections to the form **must be initialed** by the person making the change or the form will be returned.
5. Mail the completed claim form to:
   Bakers Unions & FELRA H&W Fund
   P.O. Box 1064
   Sparks, MD 21152-1064
6. Claims must be received by the *Fund Office* within 24 months from the date your disability began.

7. If you remain disabled you may be required to submit a Continuation Form as described previously. If a Continuation Form is required, the *Fund Office* will send you one.
8. If you fail to return your Continuation Form on time, all future benefits related to that disability will cease.
9. The Board of *Trustees* may, at the *Fund's* own expense, request that the person making a claim for benefits be examined as often as reasonable during the pendency of a claim

How to Pick Up Your Check

Disability claims are paid weekly and are not issued at any other time. Your check will be mailed to you each Friday unless you decide to pick it up yourself at the *Fund Office*. Checks may be picked up at either *Fund Office* location between 12:30 p.m. - 2:30 p.m. on Friday.

If you want to pick up your check at the Sparks or Landover offices, **you must notify *Participant* Services by 4:30 p.m. on Wednesday**. If you do not, your check will be mailed automatically. Call toll free at (866) 662-2537. **Only the *Participant* may pick up a check.** For your protection, photo identification is required. Your check will **not** be released if you do not have proof of identity. Holidays may cause a change in the check pick-up schedule.

Withholding Income Taxes

A form reporting the total benefits paid in a calendar year will be provided to you each year by the *Fund* or your *Participating Employer*. A copy will be sent to the Internal Revenue Service. You may request that taxes be withheld from your weekly benefit check provided:

1. You submit a signed IRS Form W-4S for federal withholding to the *Fund Office*; **and**
2. The amount to be withheld is not less than $4.00 per day or $20.00 per week.

Withholding will not take place if the amount you wish to have withheld will reduce the weekly benefit amount to $10.00 or less. Withholding on partial weeks will be pro-rated.

Social Security
Federal law requires that Social Security and Medicare Tax (FICA) be withheld from your Weekly A& S benefits and forwarded to the federal government. Your *Participating Employer* also pays FICA on your Weekly A&S benefit payments. There are no forms necessary for you to fill out for FICA withholding.

Federal Unemployment Taxes
Federal law requires that federal unemployment taxes (FUTA) be withheld from your Weekly A&S benefits and forwarded to the federal government. Your *Participating Employer* pays FUTA on your Weekly A&S benefit payments. There are no forms necessary for you to fill out for FUTA withholding.

Workers' Compensation – Denied Claims
If you apply for Workers' Compensation and your claim is denied by either your *Participating Employer* or your *Participating Employer*'s insurance carrier, you may apply to this *Fund* for Weekly Accident & Sickness Benefits. See the "Workers' Compensation" section on page 52.

Modified/Light Duty
The *Fund* does not pay Accident & Sickness benefits if you are partially disabled and return to work on modified or light duty.

CIGNA HEALTHCARE

Participant and Eligible _Dependent_s in Plans 1, 2 and 3.
Spouses are not covered in Plan 3.

You MUST use a Cigna HealthCare PPO provider in order to be covered, with limited exceptions under the Fund! Very important!

Cigna HealthCare is a network of *Physician*s, *Hospital*s and other health care providers which offer medical and *Hospital* services at reduced rates. When you use a Cigna HealthCare *Physician* or *Hospital*, both you and the *Fund* save money because the total amount of the bill is lower (if the total bill is lower, it follows that the amount for which you are responsible is also lower).

Cigna HealthCare **discounts** claims when you use a participating provider, **but Cigna HealthCare is not your insurance carrier! Your benefits are provided through the Bakers Union & FELRA Health and Welfare Fund.**

The Cigna HealthCare PPO network contains over 1,000,000 credentialed primary and specialty care physicians and facilities nationwide. To find a participating provider, contact Cigna's health information line at (800) 768-4695 or check with the Cigna website at www.cignasharedadministration.com. Click on the "find a doctor" tab, then select PPO.

At your appointment, show your *Fund* ID card and verify that the *Physician* or *Hospital* still participates with Cigna HealthCare. **Write AM0126 on your itemized bill**. This is how Cigna HealthCare knows exactly who you are and where to send your claim after they discount it.

If you used a Cigna HealthCare provider, send your medical/*Hospital* claim to:

Cigna HealthCare
P.O. Box 188004
Chattanooga, TN 37422

Cigna HealthCare will discount your claim and forward it to the *Fund Office* for processing.

Cigna HealthCare providers should **not** require payment at the time of your visit. If the provider attempts to collect payment, remind him/her that payment will be made by the *Fund* after the claim has gone to Cigna HealthCare for discounting. The amount of the reduced charge for which you are responsible will be shown on your Explanation of Benefits ("EOB") which you will receive after the *Fund Office* has processed your claim.

Exceptions to Mandatory Use of Cigna HealthCare

There are some exceptions to the mandatory Cigna HealthCare requirement. They are:

- Emergencies (inpatient or outpatient) which occur outside the Cigna HealthCare area.
- Eligible *Dependent* students who attend a school outside the Cigna HealthCare network area are not required to use a Cigna HealthCare provider.
- Anesthesiology claims from non-Cigna HealthCare providers ONLY if: (1) the *Participant* uses a participating surgeon/*Physician*, (2) the service is performed at a participating facility/*Hospital* and (3) the member followed all other *Fund* rules for coverage of the service.
- When this Plan's coverage is secondary, a Cigna HealthCare PPO provider is not required.
- Ambulance transport in emergency situations.

ACA PREVENTIVE SERVICES BENEFIT
AS OF JANUARY 1, 2015

Preventive Services Benefit Overview

This Fund provides coverage for certain preventive services as required by the Patient Protection and Affordable Care Act of 2010 (ACA). Coverage is provided on an in-network basis only, with no cost sharing (for example, no deductibles, coinsurance, or copayments), for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics *Bright Futures* guidelines and HRSA guidelines relating to services for women.

In-network preventive services that are identified by the Fund as part of the ACA guidelines will be covered with no cost sharing. This means that the service will be covered at 100% of the Fund's allowable charge, with no coinsurance, copayment, or deductible.

If preventive services are received from a non-network provider, they will not be eligible for coverage under this preventive services benefit.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Fund will determine whether a particular benefit is covered under this preventive services benefit.

The following services are covered under the Fund's preventive services benefit with no cost sharing.

Covered Preventive Services for Adults

- One-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
- Alcohol misuse screening and counseling: Screening and behavioral counseling interventions to reduce alcohol misuse by adults ages 18 and older, including pregnant women, in primary care settings.
- Blood pressure screening for all adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a *Physician* visit.
- Cholesterol screening (lipid disorders screening) for men aged 35 and older and women aged 45 and older; men aged 20 to 35 if they are at increased risk for coronary heart disease; and women aged 20 to 45 if they are at increased risk for coronary heart disease.
- Colorectal cancer screenings (fecal occult blood testing, sigmoidoscopy, and colonoscopy) for adults age 50 to 75, including bowel preparatory medications as required. The test methodology must be medically appropriate for the patient. The Fund will not impose cost sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure.
- Depression screening for adults.
- Type 2 diabetes screening for asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
- Diet counseling for adults at higher risk for chronic disease.
- Exercise or physical therapy for community-dwelling adults age 65 or older who are at increased risk for falls.
- HIV screening for all adolescents and adults ages 15 to 65 and for younger and older individuals at increased risk.

- Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Screening includes measurement of BMI by the clinician with the purpose of assessing and addressing body weight in the clinical setting.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
- Syphilis screening for all adults at increased risk of infection.
- Tobacco use screening for all adults and cessation interventions for tobacco users.
- Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.
- Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.

Covered Preventive Services for Women, Including Pregnant Women

- Well woman office visits for women ages 21 to 64, for the delivery of required preventive services, including preconception and prenatal care.
- Anemia screening on a routine basis for pregnant women.
- Bacteriuria urinary tract or other infection screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
- BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling. The Fund will also cover BRCA 1 or 2 genetic tests without cost sharing, if

appropriate as determined by the woman's health care provider.

- Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every 1 to 2 years for women aged 40 and older.
- Breast cancer chemoprevention counseling for women at higher risk. The Fund will pay for counseling by *Physician*s with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention.
- Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment. The Fund may pay for purchase of lactation equipment instead of rental, if deemed appropriate by the plan administrator.
- Cervical cancer screening for sexually active women who have a cervix. Provided to women ages 21 to 65 with cytology (Pap smear) once every three years.
- Human papillomavirus testing for women ages 30 and older with normal Pap smear results, once every three years as part of a well woman visit.
- Chlamydia infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.
- FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods, including barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. The Fund may cover a generic drug without cost sharing and charge cost sharing for an equivalent branded drug. The Fund will accommodate any individual for whom the generic would be

medically inappropriate, as determined by the individual's health care provider. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.

- Gonorrhea screening for all sexually active women, including those who are pregnant, if they are at increased risk for infection (i.e., young or have other individual or population risk factors), provided as part of a well woman visit. The Fund will pay for the most cost-effective test methodology only.
- Counseling for sexually transmitted infections, once per year as part of a well woman visit.
- Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- Osteoporosis screening for women. Women age 65 and older and younger women whose risk of fracture is equal to or greater than that of a 65-year old white woman who has no additional risk factors will be eligible for routine screening for osteoporosis. The Fund will pay for the most cost-effective test methodology only.
- Rh incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D) negative.
- Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes.
- Tobacco use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users.

- Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit.
- Screening and counseling for interpersonal and domestic violence, as part of a well woman visit.

Covered Preventive Services for Children

- Well baby and well child visits from birth through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will including the following age-appropriate screenings and assessments:
  - Developmental screening for children under age 3, and surveillance throughout childhood
  - Behavioral assessments for children of all ages
  - Medical history
  - Blood pressure screening
  - Depression screening for adolescents ages 11 and older
  - Vision screening
  - Hearing screening
  - Height, weight and body mass index measurements for children
  - Autism screening for children at 18 and 24 months
  - Alcohol and drug use assessments for adolescents
  - Critical congenital heart defect screening in newborns
  - Hematocrit or hemoglobin screening for children
  - Lead screening for children at risk of exposure
  - Tuberculin testing for children at higher risk of tuberculosis
  - Dyslipidemia screening for children at higher risk of lipid disorders
  - Sexually transmitted infection (STI) prevention screening and counseling for sexually active adolescents
  - Cervical dysplasia screening at age 21
  - Oral health risk assessment

- Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children

(such as hypothyroidism screening for newborns and sickle cell screening for newborns).

- Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce the risk for skin cancer.
- Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
- HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.
- Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

Immunizations

Routine adult immunizations are covered for you and your covered eligible *Dependent*s who meet the age and gender requirements and who meet the CDC medical criteria for recommendation.

- Immunization vaccines for adults—doses, recommended ages, and recommended populations must be satisfied:
  - Diphtheria/tetanus/pertussis
  - Measles/mumps/rubella (MMR)
  - Influenza
  - Human papillomavirus (HPV)
  - Pneumococcal (polysaccharide)
  - Zoster
  - Hepatitis A
  - Hepatitis B
  - Meningococcal
  - Varicella

- Immunization vaccines for children from birth to age 18—doses, recommended ages, and recommended populations must be satisfied:
  - Hepatitis B
  - Rotavirus
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenzae type b
  - Pneumococcal
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Varicella
  - Hepatitis A
  - Meningococcal
  - Human papillomavirus (HPV)

Preventive Medications

- Aspirin to prevent cardiovascular disease for men age 45 to 79 years and for women age 55 to 79 years.
- Oral fluoride supplements for preschool children age 6 months to 5 years whose primary water source is deficient in fluoride.
- Folic acid supplements containing 0.4 to 0.8 mg for women planning or capable of pregnancy.
- Iron supplements for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
- Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea.
- Vitamin D supplements for community-dwelling adults age 65 and over who are at increased risk for falls.
- For women at increased risk for breast cancer and at low risk for adverse medication effects, risk-reducing medications such as tamoxifene or raloxifene.

Over-the-counter preventive medications require a written prescription from your *Physician*.

Office Visit Coverage

Preventive services are paid for based on the *Fund's* payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the preventive services benefit. The following conditions apply to payment for in- network office visits under the preventive services benefit. Non-network office visits are not covered under the preventive services benefit under any condition.

- If a preventive item or service is billed separately from an office visit, then the *Fund* will impose cost sharing with respect to the office visit.
- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the *Fund* will pay 100 percent for the office visit.

- If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the *Fund* will impose cost sharing with respect to the office visit.

For example, if a person has a cholesterol-screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol-screening test, the Fund will require a copayment for the office visit but not for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Fund will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit.

Well child annual physical exams recommended in the Bright Futures Recommendations are treated as preventive services and paid at 100%. Well woman visits are also treated as preventive services and paid at 100%.

Preventive Services Coverage Limitations and Exclusions

- Preventive services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Service covered for diagnostic reasons are covered under the applicable benefit, not the preventive services benefit. A service is covered for diagnostic reasons if the *Participant* or *Dependent* had symptoms requiring further diagnosis or abnormalities found on previous preventive or diagnostic studies that required additional examinations, screenings, tests, treatment, or other services.
- Services covered under the preventive services benefit are not also payable under other portions of the *Fund*.
- The *Fund* will use reasonable medical management techniques to control costs of the preventive services benefit. Specifically, the *Fund* will only cover the most cost-effective test methodology for all preventive tests and services on this

list. The *Fund* will also establish treatment, setting, frequency, and medical management standards for specific preventive services, which must be satisfied in order to obtain payment under the preventive services benefit.

- Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g., on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.
- Examinations, screenings, tests, items or services are not covered when they are investigational or experimental, as determined by the *Fund*.
- Examinations, screenings, tests, items, or services are not covered when they are provided for the following purposes:
  - When required for education, sports, camp, travel, insurance, marriage, adoption, or other non-medical purposes;
  - When related to judicial or administrative proceedings;
  - When related to medical research or trials; or
  - When required to maintain employment or a license of any kind.
- Services related to male reproductive capacity, such as vasectomies and condoms, are not covered.

CAREALLIES PROGRAMS

Participant and Eligible *Dependent*s in Plans 1, 2 and 3. Spouses are not covered in Plan 3.

CareAllies, a subsidiary of Cigna HealthCare, is the *Fund's* utilization management/review firm. CareAllies helps contain inpatient *Hospital* costs by reducing unnecessary admissions and, when appropriate, finding treatment alternatives that both you and your *Physician* find safe and effective.

All eligible *Participant*s and eligible *Dependent*s are required to have elective inpatient *Hospital* admissions certified. You or someone on your behalf must contact CareAllies toll-free at 1-800-768-4695 to pre-certify ALL non-emergency or elective (in-patient and out-patient) *Hospital* stays and within 48 hours after an emergency admission. If you fail to do this, the Fund will reduce the amount of the benefit it would have paid by 20%, up to a maximum of $1,000. This 20% or $1,000 (whichever is less) is payable by you, in addition to any other *Deductible*s or *Co-Payment*s you may be responsible for under the regular terms of your Plan. It is important that you remember to contact CareAllies.

CareAllies is required to certify the medical necessity of procedures. It does not certify that you are eligible for benefits, that the procedure or *Hospital* stay is covered under the Plan, or the amount of coverage provided by the Plan. You must verify eligibility with the *Fund Office*.

CareAllies provides advisory opinions using medically recognized standards. At no time will CareAllies interfere with the delivery of high quality care to you. You should contact CareAllies when you need to be admitted or require services for:

- Elective (non-emergency) Admissions. Certification is required prior to admission. Call CareAllies at 1-800-768-4695. An approval letter will be sent to you prior to admission.

- Emergency Admission. Notification is required within 48 hours from the time of admission or the next business day following a weekend or federal holiday, whichever comes first. Be sure you or someone on your behalf contacts CareAllies to certify your stay.
- Emergency room visits (without a *Hospital* admission) do not require certification.
- Home Health Care must be certified through CareAllies in order to be covered.
- *Hospice Care* must be certified through CareAllies in order to be covered.

Remember to contact CareAllies at 1-800-768-4695 for your *Hospital* stays. This number is also shown on the back of your *Fund* ID card.

CareAllies will monitor your stay while you are in the *Hospital* to assure appropriate length of admission. CareAllies acts in its position as advisor to the *Fund* to recommend the appropriate number of days for your *Hospital* stay. If your medical condition requires an extension of your *Hospital* stay, CareAllies should be contacted for authorization.

Locating a CareAllies Provider

To locate a CareAllies provider, log on to www.Cignasharedadministration.com or call (800) 768-4695. You will not see the name CareAllies on the website. Click on Cigna Healthcare *Physician* or *Hospital* Directory to locate a provider.

New Medical Care Enhancements

CareAllies offers members care enhancements, such as the following programs:

- **24-hour NurseLine** where you can receive helpful information from registered nurses, anytime, day or night. The toll-free telephone number for NurseLine is (800) 768-4695. To speak to a nurse, first select #3, health

information. Next, select #1 and you will be connected with a nurse.

- **Case Management Program** is a patient-focused program intended to provide assistance and care coordination to chronically or critically ill patients (e.g., cancer, serious spinal cord *Injury*, diabetes, heart disease, etc.). You may call CareAllies toll-free at (800) 768-4695 to make use of this helpful program.

- **Maternity Management Program** allows *Participant*s to receive valuable prenatal guidance and high-risk maternity screening.

- **LifeSource Organ Transplant Program** provides care coordination in transplant centers across the country as well as case management to *Participant*s and eligible *Dependent*s.

- **Healthy Rewards[SM] Program** is a discount program for weight management, nutrition, tobacco cessation, fitness, and a wide range of other popular health and wellness issues. These programs range from discounts on such items as vision care, dental care and gym membership.

- **myCareAllies.com** website offers secure, convenient, and fast access to your personal health and wellness.

To learn more about any of the above-mentioned enhancement programs, log on to www.myCareAllies.com. ***The password to log on to myCareAllies is BAKERS (password is not case sensitive).***

MINUTE CLINICS – Use for Minor Medical Conditions

As a Cigna HealthCare member, you have the opportunity to receive treatment for common ailments and injuries by going to a MinuteClinic health care center. Cigna HealthCare provides convenience care clinics throughout the country where you can receive high quality, affordable health care services. In our Mid-Atlantic area, these centers are called MinuteClinics and are conveniently located in select retail grocery stores and drug stores, as well as certain corporate office buildings and college campuses.

To Locate a Participating MinuteClinic Near You

- Log on to www.Cignasharedadministration.com.
- Select "Medical PPO Provider Directory" and then the category called "Cigna Facility and Ancillary Directory."
- Enter a zip code of the area you wish to go to and click on "Continue Search." Scroll down the screen and select "Specialty." After you click on "Convenient Care Centers," you will be able to view all the various MinuteClinics in your area.

Advantages

- No waiting for an appointment. When you need care, you walk in, and appointments usually take about 15 minutes.
- Open seven days a week, including evening hours.
- Receive high-quality medical care in a facility overseen by doctors and staffed by certified nurse practitioners and *Physician* assistants.
- Cigna HealthCare covers the cost for these services and treats MinuteCare visits the same as primary care *Physician* office visits, with appropriate co-payments and deductibles being applied.

Appeal Procedures -- Through CareAllies Programs

If you disagree with CareAllies decision of medical necessity or length of stay, you may appeal through CareAllies internal appeals process. You, your representative, or your *Physician*/health care practitioner acting on your behalf with your consent, have the right to file an appeal of the adverse clinical determination. Appeals must be submitted in writing within 180 calendar days from the receipt of the initial denial from CareAllies. *Participant*s have the right to designate an outside independent representative(s) to assist them with their appeal. A *Participant* or his/her representative who wishes to appeal should send his/her request, all relevant documentation, and the *Participant*'s written consent, to:

CareAllies Appeals
P.O. Box 188056
Chattanooga, TN 37422-8056

Or you may fax your appeal to CareAllies at (877) 830-8833. Your appeal will be acknowledged in writing. If CareAllies determines that more information is necessary, CareAllies will notify you and assist you in obtaining the necessary information. *Participant*s or their representatives may submit additional information during the review process.

Your appeal will be acknowledged in writing. Written notification of CareAllies decision will be sent to you (or to your health care provider or to your representative, as applicable) within 15 days from the date CareAllies received your request for review for services which have not yet been rendered, or within 30 days from the date CareAllies received your request to reconsider a decision regarding services that have already been performed. If additional information is required for a decision to be made on your claim, CareAllies will inform the person making the appeal and, if necessary, will assist them in obtaining the necessary information.

Once all information required for your appeal has been received, the appeal will be reviewed within either 15 or 30 calendar days (as described above) after the receipt of your appeal. The appeal will be reviewed by a person who was not previously involved in the decision and who is not a subordinate of the individual who made the initial decision. You, or your appointed representative(s) or health care provider acting on your behalf with your written consent, may extend this timeframe by writing to CareAllies. They will consider all written documents, records, and other information relevant to your appeal that you wish to provide.

Appeal to the Board of *Trustees*

You have the right to appeal to the Board of *Trustees* if you are not satisfied after exhausting CareAllies internal appeal process. If you wish to do so, you must submit your appeal to the Board of *Trustees* within 180 days from the date you received CareAllies final decision to deny your certification.

If you do not wish to go through CareAllies internal review procedure, you may appeal CareAllies' initial non-certification directly to the Board of *Trustees*. Write to the Board of *Trustees* stating your name, the *Participant*'s Social Security Number, and the reason for your appeal within 180 days from the date you received CareAllies original denial of certification of medical necessity for your inpatient stay. See also the section on "Claims Filing and Review" starting on page 146.

HOSPITAL AND MEDICAL BENEFITS

Benefits are provided through the *Fund*, not the insured.

***Participant* and Eligible *Dependent*s in Plans 1, 2 and 3. Spouses are not covered in Plan 3.**

Important!
You must use a participating Cigna HealthCare provider in order to be covered. Services performed by non-Cigna HealthCare providers will not be paid under the Fund, with limited exceptions.

Basic and Major Medical Benefits -- For Plan 1 *Participant*s

"Basic" benefits refer to benefits which are provided at 100% (up to specified limits) with no *Deductible*. Major Medical benefits cover expenses at 80% after satisfying a $300 annual *Deductible* per person ($600 per family maximum). The remaining 20% is payable by you. ***Participant*s in this group have a $4,000 per person or an $8,000 per family, annual out-of-pocket maximum,** after which time benefits for the remainder of the calendar year will be paid at 100%.

Major Medical Benefits -- For Plan 2 and Plan 3 *Participant*s

*Participant*s in this group are not eligible for "basic" benefits. Major Medical benefits cover expenses at 75% for Plan 2 *Participant*s and 70% for Plan 3 *Participant*s, after satisfying a $500 per person, per calendar year *Deductible*. The remaining 25% is payable by you. ***Participant*s in these groups have a $5,000 per person or a $10,000 per family, annual out-of-pocket maximum,** after which time benefits for the remainder of the calendar year will be paid at 100%.

Note: Plan 4 *Participant*s are not eligible for Medical Benefits.

ID Card

Each *Participant* will receive a *Fund* ID card for *Hospital*/medical benefits. If you have *Dependent* coverage, you will receive two ID cards--one for you and one for your spouse. *Dependent* children do not receive their own ID cards. This identification card will show the *Participant*'s name and member number. There is information on the card such as the telephone number for CareAllies. Always show the *Hospital* or doctor's office your medical ID card.

Locating a Cigna HealthCare Provider

To locate the most current providers in the Cigna network, log on to its website at www.Cignasharedadministration.com. The names of providers are updated regularly. If you wish to receive a Cigna Provider Directory, call the Fund office toll-free at (866) 662-2537 and we will mail one to you.

HOSPITAL AND MEDICAL COVERAGE

Hospital Benefits

Hospital benefits are provided to you and your covered *Dependent*(s) if you are admitted to a *Hospital*. *Hospital* benefits include:

Room and Board

- **For Plan 1** *Participant*s, Room and Board in a semi-private room covered at 100% for up 70 days per calendar year, with no *Deductible*. Additional inpatient days are covered under Major Medical.
- **For Plan 2** *Participant*s, all benefits are payable at 75% under Major Medical (no Room and Board allowance).
- **For Plan 3** *Participant*s, all benefits are payable at 70% under Major Medical (no Room and Board allowance).

Intensive Care Units

- **For Plan 1** *Participant*s, expenses for Intensive Care Units (ICU) will be paid at 100% of the semi-private room rate up to 70 days per calendar year, with no *Deductible*. Balances will be covered under Major Medical.
- **For Plan 2** *Participant*s, all expenses are paid under Major Medical at 75%.
- **For Plan 3** *Participant*s, all expenses are paid under Major Medical at 70%.

Inpatient *Miscellaneous Hospital Charges*

- **For Plan 1** *Participant*s, *Miscellaneous Hospital Charges* for 70 inpatient days covered at 100% with no *Deductible*. Charges for *Hospital* services beyond 70 days per calendar year covered under Major Medical.
- **For Plan 2** *Participant*s, all expenses are paid under Major Medical at 75%.
- **For Plan 3** *Participant*s, all expenses are paid under Major Medical at 70%.

Ambulance Transportation

Plan 1 *Participants*: Transportation by ambulance for emergency services within the continental United States and Canada or within the geographical boundaries of Puerto Rico and Hawaii will be covered at 100% with no *Deductible* provided the amount is deemed reasonable by the *Fund Office*. Charges which appear to be above a reasonable amount will be referred to the Board of *Trustees*, which will make a determination of payment. Transportation is provided to or from a *Hospital* only. Air transportation is covered from the city/town in which the *Injury* or *Illness* occurs to the nearest *Hospital* qualified to provide care for that *Illness* or *Injury*. If, under these circumstances, air transportation is required, it is only covered for the first trip to and from a *Hospital*.

Ambulance transportation from one facility to another in non-emergency situations is not covered. **The requirement to use a Cigna HealthCare provider is waived for emergency ambulance transportation.**

Plan 2 and Plan 3 *Participants*: Coverage provided under the same conditions as listed above but all payment is made under Major Medical at 75% for Plan 2 *Participant*s and 70% for Plan 3 *Participant*s provided the amount is deemed reasonable by the *Fund Office*. You pay 25% or 30% (based upon your Plan) *Co-Payment* for emergency medical transportation. Charges which appear to be above a reasonable amount will be referred to the Board of *Trustees*, which will make a determination of payment.

The requirement to use a Cigna HealthCare provider is waived for emergency ambulance transportation.

Participation in Approved Clinical Trials

A. Benefit Description

Charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention,

detection, or treatment of cancer or other life-threatening disease, provided the charges are those that are:
(a) Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Fund if the individual were not participating in the Approved Clinical Trial; and
(b) Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

You and your eligible *Dependent*s are eligible for payment of charges for participation in an Approved Clinical Trial if:
(a) You satisfy the protocol prescribed by the Approved Clinical Trial provider; and (b) Either: (1) The individual's network participating provider determines that participation in the Approved Clinical Trial would be medically appropriate; or (2) the individual provides the Fund with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

- An Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease. The Approved Clinical Trial's study or investigation must be (a) approved or funded by one or more of: (1) the National Institutes of Health (NIH), (2) the Centers for Disease Control and Prevention (CDC), (3) the Agency for Health Care Research and Quality (AHCRQ), (4) the Centers for Medicare and Medicaid Services (CMS), (5) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA); (6) a qualified non-governmental research entity identified by NIH guidelines for grants; or (7) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and

assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (b) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (c) a drug trial that is exempt from investigational new drug application requirements.

B. Limitations and Exclusions

No benefits will be paid for:

- Expenses incurred due to participation in an Approved Clinical Trial that are: (1) investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
- Expenses at an out-of-network provider if a network provider will accept the patient in an Approved Clinical Trial.

Emergency Room Visits

Plan 1 *Participants*: Facility charges for emergency room visits are covered with a $25 *Co-Payment* payable by you, a 20% *co-insurance* on *Physician* fees after you pay your $300 person, $600/family deductible. The *Co-Payment* will be waived if the patient is admitted to the *Hospital* on the same day as the emergency room charges are incurred. Remaining expenses are covered under Major Medical. The *Fund* will make a basic benefit payment of $10 for *Physician's* charges for services performed in the emergency room. The balance of *Physician's* charges will be payable under Major Medical. Out-of-network is covered the same as in-network if determined to be a true emergency.

Plan 2 *Participants*: All expenses are paid under Major Medical at 75% coverage with a $25 facility fee *Co-Payment* per visit. Then you pay 25% Co-Payment. Out-of-network is covered the same as in-network if determined to be a true emergency.

Plan 3 *Participants*: All expenses are paid under Major Medical at 70% coverage with a $25 facility fee *Co-Payment* per visit. Then you pay 30% co-insurance. Out-of-network is covered the same as in-network if determined to be a true emergency.

Home Health Care - *You must contact CareAllies to certify your Home Health Care program* in order for it to be covered.

- **Plan 1 *Participants***: Charges for Home Health Care services ***in lieu of Hospitalization only*** are covered at 100% with no *Deductible* up to a maximum of 70 days per calendar year. If CareAllies certifies your Home Health Care program, three home visits will be counted as one *Hospitali*zation day. Eligible expenses beyond the maximum will be paid under Major Medical.
- **Plan 2 *Participants***: All eligible expenses are paid under Major Medical at 75% for a maximum of 70 days.
- **Plan 3 *Participants*:** All eligible expenses are paid under Major Medical at 70% up to the Cigna allowed amount.

Hospice Care - You must contact CareAllies to certify your Hospice Care in order to be covered.

- **Plan 1 *Participants***: *Hospice Care* is covered at 100% with no *Deductible* for up to 70 days of care. Eligible expenses beyond the maximum will be paid under Major Medical.
- **Plan 2 *Participants***: All eligible expenses are paid under Major Medical at 75%.

- **Plan 3 *Participant*s:** All eligible expenses are paid under Major Medical at 70% up to the Cigna allowed amount.

Laboratory and X-Ray Benefit

- **Plan 1 *Participant*s**: $100 per calendar year is paid at 100% with no *Deductible*. Balances are paid under Major Medical. This benefit also applies to lab tests and x-rays requested for diagnostic purposes.
- **Plan 2 *Participant*s**: All eligible expenses are paid under Major Medical at 75%.
- **Plan 3 *Participant*s**: All eligible expenses are paid under Major Medical at 70% up to the Cigna allowed amount.

Maternity Benefits

Female *Participant*s and eligible *Dependent*s are eligible for inpatient *Hospital* benefits for maternity care (including miscarriage and legal abortion) while the patient is a covered *Participant* under the *Fund*.

Medical Expense Benefit--*Physician*'s Visits (Inpatient and Outpatient)

- **Plan 1 *Participant*s**: *Physician*'s visits, both inpatient or outpatient, are paid under Major Medical. Starting with the third visit in a calendar year (third inpatient and third outpatient), a $10 benefit is paid with no *Deductible* with the balance being paid under Major Medical.
- **Plan 2 *Participant*s**: All eligible expenses are paid under Major Medical at 75%.
- **Plan 3 *Participant*s:** All eligible expenses are paid under Major Medical at 70% up to the Cigna allowed amount.

Benefits will not be paid for more than one visit per day by the same *Physician* or for visits in connection with surgery or post-operative care, unless such visit is from a *Physician* other than the *Physician* who performed the procedure.

Visits after diagnostic surgery are not considered to be post-operative; however, benefits are not payable for visits on the same days as diagnostic surgery by the surgeon who performed the surgery, and such visits are not considered towards satisfying the waiting period.

Newborn Benefits

Inpatient charges including the nursery, Neonatal Intensive Care Units (NICU), and *Miscellaneous Hospital Charges* for the infant are payable under the baby's coverage as a *Dependent*. Coverage is not provided under the mother's plan, even for the first 30 days. See the Eligibility section for detailed information and newborn enrollment requirements.

Obstetrical Benefits

Benefits for obstetrical services are provided to any eligible *Participant* or *Dependent*. See Surgical Benefit Expense.

Organ Transplants

Organ Transplant benefits are provided for both you and your eligible *Dependent*s. Covered expenses include the reasonable and necessary cost of securing the organ or tissue for transplant and transporting it to the transplant center and of emergency transportation (if necessary) for the patient to the *Hospital* or transplant center. Non-emergency transportation is not covered. The following conditions must be met in order for organ donation to be covered:

- The procedure must be pre-approved by the *Fund Office* and CareAllies. Contact the *Fund Office* for details if an organ transplant has been recommended for you or your *Dependent*.
- A consensus must be reached by all attending *Physician*s that organ transplantation is the best course of treatment.
- The transplant center or *Hospital* must meet acceptable standards and criteria used by Medicare and must have state and federal agency approval and authorization to perform transplants.

- If securing the organ or tissue requires surgery or *Hospital* confinement that the donor would not otherwise require, the cost of securing the organ or tissue includes the donor's expenses specifically relating to the transplant. Inpatient expenses will be at the semi-private room rate for Plan 1 *Participant*s with additional expenses covered under Major Medical. **For Plan 2 *Participant*s, all expenses covered under Major Medical at 75% and 70% for Plan 3 *Participant*s.**
- If the donor is eligible for other *Hospital*/medical coverage, the *Fund* will only pay a donor's expenses as the secondary insurer, after the primary carrier has paid.

Outpatient Surgical Facility Expense Benefit

- **Plan 1 *Participant*s**: For surgery performed as an outpatient the facility charge is covered at 100% with no *Deductible*, up to the amount allowed through CARE Programs. Expenses above the CARE allowed amount are not covered.
- **Plan 2 *Participant*s**: All eligible expenses are paid under Major Medical at 75%.
- **Plan 3 *Participant*s**: All eligible expenses are paid under Major Medical at 70% up to the Cigna allowed amount.

Pediatric Services

Benefits for pediatric services are available for any properly enrolled newborn child or children born to a *Participant* or eligible *Dependent* spouse or for any newborn child or children adopted or placed for adoption with a *Participant* or eligible *Dependent* spouse if the *Participant* or eligible spouse is otherwise eligible for obstetrical benefits. *These benefits will be provided only for the first inpatient visit by a Physician for routine history and necessary examination, however, they will not be provided if the pediatric service is rendered by the same Physician who rendered obstetrical services.* **Newborn children of the *Dependent* daughters of *Participant*s are not eligible for pediatric benefits.**

Surgical Expense Benefit

- **Plan 1 *Participant*s**: Surgical expenses paid at 100%, with no *Deductible*, according to a surgical schedule (by procedure) which had been approved by the Board of *Trustees*. The maximum surgical schedule benefit, for any procedure, is $800 per procedure. Eligible expenses over $800 are covered under Major Medical.
- **Plan 2 *Participant*s**: All eligible expenses are paid under Major Medical at 75%.
- **Plan 3 *Participant*s**: All eligible expenses are paid under Major Medical at 70% up to the Cigna allowed amount.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Mental Health and Substance Abuse benefits are provided to *Participant*s and eligible *Dependent*s under your Major Medical benefits. Services must be performed in the CareAllies network to be covered.

Mental Health Benefits for Plan 1 *Participant*s and eligible *Dependent*s:

- Inpatient Care: Room and Board in a semi-private room is covered at 100% for up to 70 days per calendar year, with no deductible. Additional inpatient days are covered at 80% under Major Medical. Miscellaneous inpatient *Hospital* charges are paid at 100% with no deductible up to 70 days per calendar year. Additional days of miscellaneous inpatient *Hospital* charges are covered at 80% under your Major Medical Benefits.

- Outpatient Care: The first two visits are paid under your Major Medical Benefits, and the deductible applies. Starting on the third visit, the Fund will pay $10 for each visit, up to a maximum of $600 per calendar year, with no deductible. The remaining balance is paid under Major Medical Benefits.

Mental Health Benefits for Plan 2 *Participant*s and eligible *Dependent*s:

- Inpatient Care: Room and Board in a semi-private room is covered at 75% under Major Medical. Miscellaneous inpatient *Hospital* charges are paid at 75% under Major Medical. *Participant*s are responsible for 25% of the charges.

- Outpatient Care: After you have met your annual deductible, the Fund office will cover charges at 75% under Major Medical. *Participant*s are responsible for 25% of the charges.

Mental Health Benefits for Plan 3 *Participant*s and eligible *Dependent*s:

- Inpatient Care: Room and Board in a semi-private room is covered at 70% under Major Medical. Miscellaneous inpatient *Hospital* charges are paid at 70% under Major Medical. *Participant*s are responsible for 30% of the charges.

- Outpatient Care: After you have met your annual deductible, the Fund office will cover charges at 70% under Major Medical. *Participant*s are responsible for 30% of the charges.

Substance Abuse Benefits:

The Plan provides coverage for substance abuse treatment for you and your eligible *Dependent*s.

Benefits are provided for:

- Detoxification in a *Hospital* or qualified drug/alcohol treatment center. Detox can be done in an outpatient or inpatient setting. Where the detox is done depends on the severity of symptoms, co-morbidity, and the substance(s) being abused. **For Plan 1 *Participants***, benefits are paid at 100% up to the semi-private room rate with no deductible. **For Plan 2 *Participants***, all expenses are paid at 75% under Major Medical.

- Inpatient rehabilitation in a drug or alcohol treatment facility is covered the same as inpatient medical. **For Plan 1 *Participants***, benefits are paid at 100% up to the semi-private room rate with no deductible. **For Plan 2 *Participants***, all expenses are paid under Major Medical at 75% and **Plan 3 *Participants*** at 70% up to the Cigna allowed amount.

- Outpatient services at a *Hospital* or qualified drug/alcohol treatment center. **For Plan 1 *Participant*s**, all benefits are paid at 80% under Major Medical. **For Plan 2 *Participant*s**, benefits are paid at 75% under Major Medical and **Plan 3 *Participant*s** at 70% up to the Cigna allowed amount.

VERY IMPORTANT: You must use a Cigna/CareAllies HealthCare behavioral health provider for all mental health and substance abuse treatment in order to receive coverage. Call Cigna/CareAllies at (800) 768-4695 to find a provider before you schedule an appointment. Call CareAllies at (800) 768-4695.

Appeal Procedure for Mental Health and Substance Abuse Claims

If a claim is not covered, you, your representative, or your *Physician*/health care practitioner acting on your behalf with your consent, have the right to file an appeal of the adverse clinical determination. Appeals must be submitted verbally or in writing within 180 calendar days of receipt of the initial denial from CareAllies. *Participant*s have the right to designate an outside independent representative(s) to assist them with their appeals. A *Participant* or his/her representative who wishes to appeal should send his/her request, all relevant documentation, and the *Participant*'s written consent, when applicable, to CareAllies. *Participant*s or their representatives seeking assistance writing an appeal letter should contact CareAllies.

All appeals are formally recorded and will be acknowledged in writing. CareAllies will determine whether sufficient information has been submitted in order to complete the review process. If the information is found insufficient, CareAllies will notify the writer that additional information is required and will assist the writer in obtaining that information. *Participant*s and their representatives, including *Physician*s/health care practitioners may also submit additional information during the review process. Written notification of the decision will be sent to you, your representative, or your *Physician*/health care practitioner, as

applicable, within 15 calendar days after receiving the first level appeal request to reconsider a decision regarding services that have not yet been rendered, or within 30 calendar days after receiving the first level appeal request to reconsider a decision regarding services that have already been rendered.

Your appeal will be reviewed within either 15 or 30 calendar days, as described above, after the receipt of your appeal by a person(s) not previously involved in this matter and who is not a subordinate of the individual who rendered the initial decision. You, your representative(s) or your *Physician*/health care practitioner, acting on your behalf with your written consent, may extend this timeframe upon written request. CareAllies and/or the provider of care will review and consider all written comments, documents, and other information relevant to the appeal you wish to provide.

An expedited appeal procedure is available for health care services that are proposed, but have not been delivered, for services that are necessary to treat a condition or *Illness*, and 1) that, without immediate attention, could seriously jeopardize the life or health of the *Participant* or the *Participant*'s ability to regain maximum function, 2) in the opinion of a *Physician* with knowledge of the *Participant*'s medical condition, would subject the *Participant* to severe pain that cannot be adequately managed without care or treatment, or 3) if the *Participant* is considered a danger to himself or others. In the event an appeal qualifies as expedited, a final decision will be made and communicated verbally within 24 hours of our receipt of the request. Within one day after the final decision has been verbally communicated to you, your representative, or the health care practitioner who filed the appeal on your behalf, written verification of the appeal decision will be sent. *Physician*s/health care practitioners may request an expedited appeal by calling the Medical Affairs Department at 301-545-5759. *Participant*s may request an expedited appeal by contacting CareAllies.

If you are dissatisfied with the appeal decision, you have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974. You must exhaust appeal rights prior to bringing a civil action.

MAJOR MEDICAL BENEFITS

You must receive services at a Cigna Shared Administration network or no benefits will be paid, with limited exceptions. You must certify all inpatient *Hospital* stays with CareAllies.

Plan 1 *Participant*s
Major Medical coverage is provided for expenses incurred as a result of *Illness* or *Injury*. If the Plan provides a Basic Benefit, the Basic Benefit will be paid first, and remaining eligible balances will be processed under your Major Medical coverage. **Each covered family member must satisfy the $300 per calendar year *Deductible* (to a maximum of $600 per family) per calendar year before benefits will begin to be paid.** However, if two or more family members are injured in the same accident, only one *Deductible* will apply for expenses relating to that accident.

Covered expenses under Major Medical are paid at 80% up to the Cigna HealthCare PPO allowed amount, after you have satisfied the annual *Deductible*.

Plan 2 *Participant*s
All eligible expenses are paid under Major Medical at 75% up to the Cigna HealthCare PPO allowed amount, after you have satisfied the annual *Deductible*. **Under Plan 2, each covered person must satisfy a $300 per year *Deductible* per individual (to a maximum of $600 per family) before benefits will begin to be paid.**

Plan 3 *Participant*s

Covered Expenses (Plan 1, Plan 2 and Plan 3 Full Time *Participant*s)

The following expenses are covered under Major Medical:

1. Balances remaining after Basic coverage has paid its portion, where stated in this booklet;
2. Outpatient *Physician*'s Visits;
3. Outpatient Nursing Care Services. These include outpatient charges for the services of a Licensed Practical Nurse (LPN) or a Registered Nurse (RN) provided the care is indicated as medically necessary in writing by the patient's *Physician*. The nursing care will be covered only if the level of care can only be provided by an LPN or RN;
4. Nursing Home or Skilled Nursing Facility. The patient must go from the *Hospital* to the first available nursing or rehabilitation center in order for these services to be covered. In no event will charges be covered if more than 30 days passes between the time the patient is discharged from the *Hospital* and the time the patient check in to the nursing home or rehabilitation center;
5. *Ambulatory Surgical Facility* Services. *Physician*'s charges in an *Ambulatory Surgical Facility* are paid separately;
6. Anesthetic and its administration;
7. X-ray, radon, radium, and radioactive isotope treatments;
8. Medical Supplies. Charges for the following:
   a. Bandages and surgical dressings
   b. Surgical supplies such as appliances to replace lost physical organs or parts to aid in their functions when impaired, except that only the initial charge for such appliance shall be included;
   c. Oxygen and rental of equipment for the administration of oxygen;
   d. Rental of a wheelchair or *Hospital*-type bed;
   e. Rental of an iron lung or other mechanical equipment for the treatment of respiratory paralysis;

   Note: The *Fund* reserves the option of purchasing equipment or appliances that would otherwise be rented if

the rental of such equipment or appliances would be greater than the cost of purchasing it.

9. Expenses relating to cosmetic surgery only if the surgery was necessary for the prompt repair of a non-occupational *Injury* which occurred after the date on which the *Participant* or *Dependent* became eligible for coverage.
10. Psychological testing for diagnosis of mental disorders is covered up to the limits described in the Mental Health Benefit section on page 105.
11. Services for dental care **only in the circumstances described in this paragraph** are covered under Major Medical:
    a. Charges made by a duly qualified dentist or oral surgeon for treatment of fractures and dislocations of the jaw.
    b. The excision of partially or completely un-erupted impacted teeth, the excision of a tooth root without the extraction of the entire tooth and other incision or excision procedures on the gums and tissues of the mouth when not performed in connection with care of the gums or the extraction or repair of teeth.
    c. Medical expenses required for the prompt repair of natural teeth or other body tissues **only if the treatment is necessary as a result of a non-occupational *Injury*.**
    d. Replacement of a bridge or denture within five years following the date of its original installment under Major Medical **only if such bridge or denture is damaged beyond repair.** Dentures will only be covered under Major Medical if they are necessary as a result of accidental *Injury* which occurs while the *Participant* is eligible for benefits under the *Fund*. All other dental charges are payable under the Dental Benefit up to the limit specified in that section.
12. Charges incurred for eye refraction or eye glasses are covered under the Optical benefit unless they are necessary due to an *Injury* sustained while the *Participant* is eligible for coverage under the *Fund*, in which case they will be covered under Major Medical.

13. Chiropractic care is covered under Major Medical as follows:
    Plan 1 and 2 *Participant*s: payment for chiropractic treatment is limited to $40 per visit after satisfying the *Deductible*. There is a $5.00 co-pay per visit, payable by *Participant* or *Dependent* to the provider at the time of service. The maximum payable for chiropractic treatment is $500 per person per calendar year, and $1,000 per family per calendar year.

GENERAL EXCLUSIONS

The expenses listed below are excluded from payment **under all benefit categories, for Plan 1, Plan 2 and Plan 3 *Participant*s, unless otherwise stated.**

1. Expenses not specifically included as covered medical expenses;
2. Hearing aids, unless the hearing aid is necessary as a result of an *Injury* sustained while the *Participant* is eligible for benefits under the *Fund*;
3. Treatment of sexual dysfunction (except for erectile dysfunction drugs, such as Viagra, as specified under the Prescription Drug benefit) or trans-sexual surgery;
4. Reversal of sterilization;
5. Injection treatment of hemorrhoids, hernias, and varicose veins, except that sclerotherapy will be covered if medically necessary for thrombophlebitis, phlebitis, leg ulcers or inflammation, but not for cosmetic purposes;
6. Palliative or cosmetic foot care including, but not limited to, callus or corn paring; trimming or excision of toenails, except radical surgery for ingrown nails; treatment of chronic conditions of the foot such as fallen arches, weak feet, flat or pronated foot metatarsalgia, or foot strain;
7. Orthopedic shoes (except when joined to braces) or supportive devices for the feet, including, but not limited to arch support, heel lifts, or orthotics;
8. Treatment of temporomandibular joint dysfunction (TMJ);
9. Vision training of any kind;
10. Radial keratotomy and refractive karatoplasty for vision that can be corrected to 20/80 with the aid of eyeglasses or contacts;
11. Rehabilitative or occupational therapy not directly associated with an *Illness* or *Injury* or not required to restore a person to the activities of daily living following *Illness* or *Injury*;
12. Hypnotism and stress management. Behavior modification unless medically necessary.

13. Psychological Testing except for purposes of diagnosis.
14. Private duty nursing while *Participant* is a *Hospital* inpatient;
15. Losses resulting from an *Injury* sustained while operating or riding in or on an aircraft, or falling or in any other manner descending from an aircraft while the aircraft is in flight or motion, except as a fare-paying passenger of a commercial airline flying on a regularly scheduled route between established airports;
16. Services which would have been available to you free of charge if not for the *Fund's* coverage;
17. Charges incurred outside the United States of America except those incurred in the event of an emergency while the covered person is on vacation and within the first 90 days of the person's absence from the United States. The *Participant* may still be eligible for Weekly Accident and Sickness benefits;
18. Services rendered prior to the date the person became covered under the *Fund* or supplies purchased or rented prior to that date;
19. Benefits are not payable for cosmetic or beautifying surgery unless required as the result of a non-occupational *Injury* occurring after the date on which you become a *Participant*;
20. Complications arising from cosmetic surgery (unless the cosmetic surgery was required to treat a non-occupational *Injury* which occurred while you were eligible for benefits under this *Fund*);
21. Custodial care which is not required to be performed by an RN or LPN. Custodial services include (but are not limited to) bathing, giving oral medication, acting as a companion or sitter, assisting with personal hygiene and daily living activities;
22. Benefits will not be paid to a covered *Dependent* if that *Dependent* is also a *Participant* of this *Fund* who is eligible for benefits as an employee;
23. Work-related injuries or *Illnesse*s which are generally compensable under Workers' Compensation legislation, occupational disease act legislation, *Employer*'s liability law or other similar legislation. If your claim *would have been paid*

under Workers' Compensation if not for your failure to follow the appropriate procedural requirements (filing on time, submitting requested information, etc.), it will be treated as compensable and will be excluded from coverage under the *Fund*;

24. Services, supplies, drugs, devices, medical treatment, procedures, or care of any kind which is experimental in nature or which is not accepted medical practice by the practicing medical community as determined by the *Fund*; (See "Experimental" in the Definitions section of this booklet).
25. Charges for completion of forms or for copies of records and other paperwork;
26. Personal hygiene, beautification, comfort and convenience services and supplies are not covered;
27. Air conditioners, humidifiers, purifiers and similar equipment are not covered;
28. Expenses not medically necessary for the treatment of *Illness* or *Injury* including x-rays made without film;
29. Meals-on-Wheels and similar food arrangements;
30. Surrogate parenting, in-vitro fertilization, and all other treatments concerning infertility;
31. Treatment for learning disabilities, hyperkenetic syndromes, mental retardation, developmental delay, attention deficit disorders, autism or oppositional defiant disorders is not covered. This exclusion does not apply to diagnostic testing to determine the existence of such conditions;
32. Gastric by-pass or bubble, or similar procedures, to treat obesity;
33. Treatment of obesity or weight loss, or physical fitness or exercise programs;
34. Telephone consultations with patients or charges for failure to keep a regularly scheduled appointment;
35. Pre-admission diagnostic testing relating to an inpatient admission which is <u>not</u> covered under the Plan;
36. Nutritional counseling and services, supplies or medications primarily for dietary control;
37. Domestic or housekeeping services;

38. Expenses arising from participating in the commission of a crime or act of violence or resulting from war or an act of war;
39. Services or supplies which are in excess of the Cigna HealthCare PPO allowed amount or in excess of the amount approved by CARE Programs;
40. Pre-marital testing;
41. Preventive care and vaccinations, unless specifically stated as being covered;
42. Expenses which can be recovered by a third party (Workers' Compensation, a no-fault car insurance policy, or any other third party, whether or not you make a claim to recover such expenses);
43. Losses resulting from self-inflicted or self-induced *Injury* or *Illness*.

PRESCRIPTION DRUG BENEFIT

Benefits are provided through the *Fund*, not insured.
Services provided through OptumRx

***Participant*s and Eligible *Dependent*s**

The *Fund* will pay for **medically necessary** prescription drugs which include compounding, legend drugs, insulin and other prescribed drugs as specified. Prescriptions must be written by a *Physician* legally licensed to practice medicine.

ID Card

You will receive a white ID card directly from OptumRx. Show the card to the pharmacy and pay the appropriate *Co-Payment* when you go to pick up your prescription. There are no claim forms to complete.

If You Lose Your Prescription ID Card

If you lose your prescription card, call OptumRx at (888) 869-4600 and request a replacement card.

Available Pharmacies

Your prescription benefit through OptumRx uses a "labor friendly" pharmacy network. That means you may use your prescription card at any Safeway, Giant/SuperG, Acme, Pathmark, ShopRite or Rite Aid pharmacy.

***Co-Payment*s Per Prescription**

There is a *Co-Payment* per prescription which you pay to the pharmacy at the time you pick up your prescription. The co-pays are as follows:

- $10 for a generic drug.
- $15 for a brand name drug which is on Optum's formulary list.
- $30 for a brand name drug which is not on Optum's formulary list.

The OptumRx Formulary Advantage Program includes the following drug classes:

1. Albuterol Inhalers
2. Androgens
3. Basal Insulin
4. Antipsychotics
5. Diabetic Test Strips
6. Fibrates
7. FSH Agents
8. GLP Inhibitors
9. Growth Hormones
10. Hepatitis C
11. Insulin
12. Interferons
13. Multiple Sclerosis Drugs
14. Ophthalmic Prostaglandins
15. Sleep Aids
16. SSRI's
17. TNF Inhibitors

Certain Conditions Apply

The above drug classes are added to the OptumRx Formulary Advantage Program subject to the following conditions:

1. All *Participant*s currently receiving any of the above drugs are grandfathered – i.e., exempt from the requirements of the Formulary Advantage Program, for the applicable drug category. Should a *Participant* stop taking the applicable drug for more than six months, he/she will lose grandfathered status; and

2. Any *Participant* for whom a *Physician* specifically prescribes a brand name drug/"targeted medication" because the *Participant*, for any reason, cannot take a generic or preferred alternative drug, will also be exempt from the Formulary Advantage Program for that drug category.

Mail Order Service

The mail order program for maintenance drugs are provided through OptumRx home delivery. Through this program, you can receive a 90-day supply of your prescription medications delivered right to your door. Remember by using the mail order

program, you only pay the cost of two (2) co-payments but receive a three (3) month supply of the drug – this saves you money. If you have any questions, please call OptumRx member services at (888) 869-4600.

Optum Rx Website

You can access the Optum R_x member website by logging onto www.optumrx.com/myCatamaranRx. Here you can receive information regarding your prescription drug benefits, locate local network pharmacies, compare your co-payment at each pharmacy, access an exercise calculator via "Healthy Links", and receive information about dietary guides and recipe substitutes. To access the website enter your member identification number (ID), located on your prescription card, and your date of birth in the "Members Login" box located on the right side of the screen; then click "Login."

Prescription Benefit Rules

The *Fund* will cover the balance of the cost of the prescription, subject to the following:

1. Prescriptions are filled at a participating pharmacy.
2. You present your prescription ID card at the time you pick up your prescription.
3. Prescriptions will be filled to a maximum of 30 day supply or up to a 90 day supply if the mail order program is used for maintenance drugs.
4. The prescription must be medically necessary.
5. Refills must be authorized by your *Physician*.
6. Generic drugs are preferred. If you request a brand name drug when a generic is available, you must pay the difference in cost between the generic and brand name in addition to the appropriate *Co-Payment*.

Diabetic Supplies

The *Fund* will cover the following diabetic supplies through Optum: test strips, calibration solution, lancet device, lancets,

blood glucose meters, and syringes. Appropriate *Co-Payment*s apply.

Quantity Limitations and Prior Authorization Requirements
Certain drugs are covered only with certain quantity limitations or after obtaining prior authorization from the *Fund Office*. The drugs below have limitations to their coverage or require prior authorization. The *Trustees* may add or remove drugs from this list as deemed necessary.

The following medications have quantities limited to the dosage shown on the chart below. Higher quantities require either a prior authorization or approval by the Board of *Trustees*.

Drugs Which Have Quantity Limitations

Drug	Prescribed For
Axert = 12 /30 days Amerge, Imitrex = 9 / 30days Relpax, Zomig = 6 /30days Imitrex nasal spray 20mg = 12 /30days Imitrex Kit= 4 / 30days	Migraine Medication (Triptans)
Ambien, Sonata, Lunesta 15 per 30 days	Sedative / Hypnotic Medication
Anzemet = 5 /30days Kytril= 10 /30days Zofran 4 & 8mg = 15 /30 days Zofran 24mg = 5/30 days	Anti-Emetics Medication (for Nausea)
Stadol Nasal Spray = 4 sprays/ 30 days Toradol 20 / 5days	Analgesic Medication

Cialis, Levitra, Viagra = 6/30 days	Erectile Dysfunction Medication
Celebrex 100 mg., 200 mg = 30 pills/30 days	Anti-inflammatory Drugs (COX-2 Inhibitors)

PRIOR AUTHORIZATIONS

If you need a prior authorization, contact Optum at (888) 869-4600
and ask for the Prior Authorization department. Optum will fax a form to your doctor to be completed. Once the form is completed and returned, Optum will review the form and if your condition warrants, put a prior authorization in place so your prescription will be covered.

Drugs Which Require Prior Authorization

Drug	Prescribed For
Oral/Topical Contraceptives for *Dependent*s.	Covered if medically necessary. Not covered solely for prevention of pregnancy.
Provigil	Wakefulness promoting agent
Lotronex/Zelnorm	Irritable Bowel Syndrome (IBS)
Oral Antifungals (Lamisil / Sporanox)	Treat fungal infection of finger and toenails
Forteo	Osteoporosis
Proton Pump Inhibitors (above doses of 1 per day) (i.e. Aciphex, Protonix, Nexium, Prevacid)	Treat Acid Reflux Disease
Psoriasis Agents (Raptiva, Amevive, Enbrel, Remicade)	Psoriasis Immunotherapy – chronic

Xolair	Allergy related asthma
Weight loss drugs	Medically necessary for treatment of obesity
Retinoids (after age 26)	Severe acne after failure of first-line agents
Growth Hormones	Growth/Pituitary disorders
Botox	Severe migraines, hyperspaspicity

STEP THERAPY PROGRAM

Step Therapy is a process that requires the use of a preferred medication or specific criteria to be met before a particular drug can be approved. If a prescription for a medication requiring Step Therapy is presented to the pharmacy, your prescription profile is instantly reviewed when the claim is electronically submitted to Optum Rx. Based on the history in your file, the prescription claim may be approved automatically. If the prescription rejects, two options exist. The pharmacist may call the *Physician* to obtain a prescription for the preferred medication, or you may pursue approval of the prescription through the Prior Authorization process.

If you currently take any of the medications listed in the Step Therapy Program, you can avoid an extra trip to the pharmacy by asking your *Physician* for a prescription for the preferred medication. If you and your *Physician* decide this is not appropriate therapy for you, please contact Optum Rx to begin the Prior Authorization process.

A fax will be sent to the prescribing *Physician* requesting documentation of your diagnosis and previous therapy. Once the *Physician* completes and returns the form, a clinical pharmacist will review it to determine whether you meet the approval criteria.

The table below lists medications included in Step Therapy Programs:

Drug Class	Preferred Product	Affected Medications
Proton Pump Inhibitors	Prilosec OTC*	Aciphex, Nexium, Prevacid, Protonix
Non-Sedating Antihistamines	Claritin OTC*	Allegra/D, Clarinex/D, Zyrtec/D
Anti-inflammatory Cox-2 Inhibitors	Traditional NSAIDs (ibuprofen, naproxen)	Celebrex
Angiotensin II Receptor Blockers (ARBs)	ACE Inhibitors (Captopril, Enalopril, Fosinopril, Lisinopril, Quinapril, etc.)	Atacand, Avapro, Benicar, Cozaar, Diovan, Hyzaar, Micardis, Teveten
Dermatological	Generic topical steroid (hydrocortisone, triamcinolone, fluocinonide)	Elidel and Protopic
Antiasthmatic Agents	Albuterol	Xopenex
Allergic Rhinitis (Runny nose, watery/itchy eyes)	Steroid Nasal Spray plus an Antihistamine	Singulair Members who use Singulair for asthma control are exempt from this requirement. Members less than 18 years of age are also exempt from this requirement.

Treatment of allergies	Zyrtec or Zyrtec D OTC	Clarinex, Clarinex D, Xyzal

*** Prilosec Over-the-Counter ("OTC") and Claritin Over-the-Counter ("OTC") will be covered at the generic co-pay with a valid prescription. Bring the prescription slip to the pharmacy along with the Prilosec or Claritin. Show the pharmacy your Optum prescription card and explain that although the drug is sold over-the-counter, it is covered under your prescription benefit.**

SPECIALTY PHARMACY/BRIOVA RX ASCEND PROGRAM

Prescriptions for specialty medications are provided through Briova Rx and not through your retail pharmacy. Specialty medications are used to treat genetic or rare chronic conditions like multiple sclerosis, hepatitis C, Crohn's disease, Gauchers disease, hemophilia, immune system/IVIG, oncology, psoriasis, rheumatoid arthritis, transplants, and HIV/AIDs.

If you have a prescription for a specialty drug, it will not go through at the retail pharmacy level -- the pharmacist will receive a message indicating you must get the drug from the Briova Rx Ascend Specialty pharmacy.

Call Briova Rx at 1-855-427-4682 to be assigned a care coordinator and to set up delivery of your medication. Your prescription will be delivered directly to your door (or to another location of your choosing). There are pharmaceutical staff available to answer any questions you may have about your medication.

Exclusions under Prescription Drug Benefit

The prescriptions listed below are **not covered** under the Plan.

- Over-the-counter drugs or any drug which can be obtained without a prescription ***except*** Prilosec and Claritin as specified in the Step Therapy section.
- Prescriptions for drugs whose use is primarily for cosmetic purpose
- Prescriptions available without charge or for which payment is available under state, federal or local programs including Workers' Compensation
- Diagnostic drugs
- Intravenous drugs except Procrit and Activase
- Rhogam
- Serums
- Any charge for the administration of a drug, including insulin
- Experimental or investigational drugs

- Drugs not approved by the Food and Drug Administration (FDA)
- Unauthorized refills
- Immunizations, immunization agents, blood or blood plasma, and biological sera
- Medication for a patient confined to a rest home, nursing home, extended care facility or similar entity
- Any charge where the cost of the drug is less than the *Participant*'s *Co-Payment*
- Non-insulin syringes
- Infant formulas
- Liquid nutritional supplements
- Over-the-Counter medications written on a valid prescription except Claritin OTC and Prilosec OTC as specified in the Step Therapy section
- Topical dental fluoride
- Respiratory therapy supplies
- Norplants, IUDs, diaphragms, OTC (over-the-counter) and miscellaneous contraceptives
- Fertility drugs
- Electrolyte replacement
- Any drug for cosmetic purposes
- Hair replacement products including Rogaine and similar products
- All other medical supplies

Reimbursement If You Paid for Your Prescription In-Full

It's best to have your Prescription Drug ID card with you at all times. If you had to pay for your prescription in full at the pharmacy (for example, you don't have your card with you and the pharmacy does not have your information on file), however, you may request reimbursement from Optum. You will be reimbursed based on the **retail cost** of the drug (you lose the discount the pharmacy receives by processing the claim on the computer), less the appropriate *Co-Payment*.

Follow These Steps for Reimbursement

- Request a reimbursement form from the *Fund Office* (not from Optum). This is important because the form tells Optum who you are and your level of coverage.
- Return the form to the *Fund Office* along with your itemized receipt (the detailed receipt usually stapled to your pharmacy bag, not the cash register receipt).
- You must submit a request for reimbursement within **730 days (2 years) from the date the prescription was filled.** After that time, your reimbursement will not be processed.
- Remember you will **only** be reimbursed based on the retail cost level minus the appropriate *Co-Payment*.

Reimbursement generally takes about 4 weeks.

Appeal Process

If a *Participant* or covered *Dependent* wishes to appeal a prescription drug claim denial or limitation, he/she must address the appeal to the Board of *Trustees*. Optum Rx does not have an internal appeal process.

See the section "If Your Claim Is Denied -- Appeal Procedures" on page 149 for information on how to appeal to the Board of *Trustees*.

DENTAL BENEFITS

Benefits are provided through Denex Dental.
Benefits are insured.

***Participant* and Eligible *Dependent*s in Plans 1, 2, 3 and 4.**
Only excludes medical and Rx.

Dental Benefit

The *Fund* provides dental coverage through Denex Dental ("Denex"). The Denex plan uses the Dentemax Dental network of dental providers. If you use a Denex/Dentemax provider, you will receive the higher level of benefit, but you are not *required* to use one. If you use a non-Dentemax network provider, you will still be covered but the level of benefits is less (meaning the amount you pay is more).

You must pay a $50 per person or $150 per family annual deductible before this Plan begins to pay for services.

You will receive a "Certificate of Coverage" from Denex. The booklet describes covered procedures and exclusions under the Dental portion of your benefits. You are responsible for paying any amounts remaining after Denex has paid its portion. Remember that you receive the best coverage if you use a Denex/Dentemax network provider.

Orthodontic Benefit

The Plan pays 100% of eligible orthodontic expenses on a monthly basis up to a lifetime maximum of $2,000 per eligible *Participant* and *Dependent* up to age 26, paid in 24 equal installments. Orthodontic treatment for patients age 26 and over is not covered.

ID Card

Denex will send you an ID card for your dental benefits. Show the ID card to the dentist each time you go for services. To choose a provider for the first time (or to change a provider) call Denex

Dental at (866) 433-6391. Once you have been to the provider for the first time, you may make future appointments directly with the provider. If you need a Denex provider directory, you may call the number shown above to ask for one or visit Denex's website at www.DenexDental.com. Choose the tab for Denex plans and there will be an option to view participating provider.

Appeal Rights -- If Your Claim Is Denied

Denex does not require pre-authorization of any Covered Service. In addition, Denex does not evaluate the medical necessity of any Covered Service provided. The only determinations made by Denex are Coverage Decisions.

A dental provider or other authorized representative may file a claim or an Appeal on a Covered Person's behalf. All references in this section to "Covered Person" and "Covered *Dependent*" will include an authorized representative. The Dental Plan may require proof that a person is an authorized representative.

Definitions under Denex Dental

Appeal - A protest filed by a Claimant with the Dental Plan under its internal appeal process regarding a Coverage Decision concerning the Claimant.

Appeal Decision – A final determination by the Dental Plan that arises from an Appeal filed with the Dental Plan under its appeal process regarding a Coverage Decision concerning a Claimant.

Authorized Representative – An individual authorized by the Claimant or state law to act on the Claimant's behalf to submit Appeals and file claims. A Provider may act on behalf of a Claimant with the Claimant's express consent, or without a Covered Person's express consent in an emergency situation.

Claimant - The Covered Person or a dental provider filing on the Covered Person's behalf.

Commissioner – The Maryland Insurance Commissioner.

Complaint - A protest filed with the Maryland Insurance Administration involving a Coverage Decision concerning a Claimant.

Coverage Decision – An initial determination by the Dental Plan or its representative, based on a policy provision and not medical necessity, that results in non-coverage of a dental service. A "Coverage Decision" includes non-payment of all or any part of a claim.

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

Filing Date - the earlier of:

1. Five (5) days after the date of mailing, or
2. the date of receipt.

Notice of Benefit Determination – A notice of approval, denial, reduction or termination of benefits or the failure to provide or pay for benefits.

Post-Service Appeal – An Appeal of a Coverage Decision for a service that has already been provided.

Post-Service Claim – A claim for dental services that the Claimant has already received or any claim that is not a Pre-Service Claim. The Dental Plan will send a Notice of Benefit Determination (Explanation of Benefits) to the Claimant or Authorized Representative within 30 days after we receive the claim. The Notice of Benefit Determination will inform the Claimant or Authorized Representative that we have received the claim and the status of the claim as follows:

- The claim was paid; or

- The Dental Plan is refusing to reimburse all or part of the claim and the reason for the refusal; or
- The Dental Plan needs additional information to determine if all or part of the claim will be reimbursed and what the specific information is; or
- The claim was not submitted correctly and what information is necessary to complete the claim.

The Claimant or Authorized Representative has 45 days from the receipt of the notice to provide the additional information.

If the request is not approved, the Claimant or Authorized Representative may Appeal the decision as described below.

Content of Coverage Decision Notice

When a claim is denied, in whole or in part, the oral or written notice will include the following, as applicable:

1. The specific reason why the dental service was denied;
2. The specific plan provision on which the decision is based;
3. A description of any additional material or information necessary for the Claimant to perfect the claim, and an explanation of why such material or information is necessary;
4. That the Claimant has a right to file an Appeal with the Dental Plan, a description of the Dental Plan's internal appeal process, and the time limits applicable to such process;
5. The name, business address and business telephone number of the person responsible for the Dental Plan’s internal appeal process;
6. The address, telephone and facsimile number of the Maryland Insurance Administration;
7. Statement that the Health Advocacy Unit is available to assist the Covered Person in both mediating and filing an appeal under the Dental Plan's internal appeal process;
8. The address, telephone number, facsimile number, and email address of the Health Advocacy Unit; and.
9. A statement of the Claimant's right:

a. To file a Complaint with the Maryland Insurance Administration within 60 working days after receipt of the Dental Plan's Appeal Decision for a Coverage Decision;
b. To bring a civil action under section 502(a) of ERISA following an Appeal Decision by the Dental Plan.

In addition, the notice will advise the Claimant that he or she is entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim decision.

Help Available from the Health Advocacy Unit

If a Claimant wants to dispute a Coverage Decision, there is help available from the Health Advocacy Unit. The Health Advocacy Unit can help a Claimant prepare an Appeal to file under the Dental Plan's internal appeal process. The Health Advocacy Unit can also attempt to mediate a resolution to the dispute, but at any time during a mediation attempt, the Claimant may file an Appeal with the Dental Plan. The Health Advocacy Unit is not available to represent the Claimant or accompany the Claimant during any proceeding of the Dental Plan's internal appeal process. A Claimant may contact the Health Advocacy Unit at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
Phone: 410-528-1840 or toll-free: 877-261-8807,
Fax: 410-576-6571
Email: http:/www.oag.state.md.us

Internal Appeal Process - Right to Appeal a Coverage Decision

If a Claimant does not agree with a Coverage Decision, the Claimant may first contact the Dental Plan's Member Services Department at (800) 242-0450 to discuss the specific reasons for the Coverage Decision. The Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all

documents, records, and other information relevant to the claim. At any time the Claimant may submit additional documentation to support the claim.

A Claimant may file a written Appeal within 180 days after the date of receipt of notice of the Coverage Decision.

The Appeal should include written comments, documents, records and other information relating to the claim to support the Appeal, and must be sent to the following address:

Denex Dental
Appeals
P.O. Box 7402
London, KY 40742

The review will not afford deference to the initial Coverage Decision, and will be conducted by a person who is neither the person who made the initial Coverage Decision, nor the subordinate of such person. The review will take into account all documents and comments that support the Claimant's position, even if the information was not submitted or considered in making the initial Coverage Decision.

Post-Service Claim Appeals

The Dental Plan will notify a Claimant in writing of an Appeal Decision for a Post-Service Claim, within a reasonable time, but not more than 30 days after the Appeal Decision is made, and not more than 60 days after the date the Appeal was filed.

Content of Appeal Decision Notice

When a claim is denied on Appeal, in whole or in part, written notice will include the following as applicable, in clear understandable language:

1. The specific factual basis for the decision;
2. The specific plan provision on which the decision is based;
3. The name, business address and business telephone number of the person responsible for the Dental Plan's internal appeal process for Coverage Decisions;

4. The identification of the expert whose advice was obtained for the review, if any, without regard to whether the advice was relied upon in making the Appeal Decision;
5. A statement of the Claimant's right:
   a. To file a Complaint with the Maryland Insurance Administration within 60 working days after receipt of the Dental Plan's Appeal Decision for a Coverage Decision.
   b. To bring a civil action under section 502(a) of ERISA following an Appeal Decision by the Dental Plan.
6. The address, telephone and facsimile number of the Maryland Insurance Administration.

In addition, the notice will advise the Claimant that he or she is entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination.

Responsibility for Internal Review Process

The representative of the Dental Plan who has responsibility for its internal appeal process is:

Dental Director
Denex Dental
P.O. Box 7402
London, KY 40742

Voluntary Appeals Process and Right to File under ERISA

If a Covered Person does not agree with an Appeal Decision, the Covered Person may choose:

1. To file a Complaint with the Maryland Insurance Administration as described below; or
2. To file a civil action under section 502(a) of ERISA.

Complaints – External Review -- Right to File Complaint
A Claimant has the right to file a Complaint with the Maryland Insurance Administration within 60 working days after receipt of the Dental Plan's Appeal Decision for a Coverage Decision.

A Complaint may be filed with the Maryland Insurance Administration if an Appeal Decision is not received within 60 days after the Filing Date of an Appeal for a Coverage Decision.
Complaints may be sent to:

Maryland Insurance Administration
Life and Health Complaints Unit
525 St. Paul Place
Baltimore, MD 21202
Telephone: 800-492-6116 or 410-468-2000
Fax: 410-468-2270

Because there is no preauthorization of services, a claim can only involve a denial for a service already provided. Therefore, the internal appeal process described above must be exhausted prior to filing a Complaint.

Other Complaints
If a Covered Person has a complaint for any reason other than denial of a claim as stated above, such as a complaint about the Covered Person's dentist/dental office or a non-quality of care issue, the Covered Person should first contact Member Services at 800-242-0450.

If the complaint is not resolved, the Covered Person does not have to exhaust the Appeal Process before contacting the Maryland Insurance Administration about filing a complaint. The Covered Person may contact:

Maryland Insurance Administration
Life and Health Complaints Unit
525 St. Paul Place
Baltimore, MD 21202
Telephone: 800-492-6116 or 410-468-2000
Fax: 410-468-2260

Dental Exclusions and Limitations

All Benefits are subject to the following exclusions and limitations and frequency limits:

1. Coverage is limited to those services set forth in the Schedule of Covered Procedures. If a service is not listed, it is not included.
2. Benefits for prophylaxis (ADA Code 1110) will not be paid if performed on the same date of service with periodontal cleaning treatment. (ADA Code 4355, 4910, 4341, 4342.)
3. Examination and prophylaxis, including scaling and polishing is limited to once every six (6) months.
4. Bitewing x-rays are limited to once every twelve (12) months, limited to four (4) bitewings except for bitewing x-rays required under code 0277.
5. Full mouth x-rays (ADA Code 0210) or panoramic x-rays (ADA Code 0330) are limited to once every sixty (60) months, except when taken for diagnosis of 3rd molars, cysts, or neoplasms.
6. Consultation (ADA Code 9310) performed by a Specialist will not be paid if the dental procedure is performed on the same date of service by that Specialist. Consultation should already be included with the dental procedure.
7. For Eligible Covered *Dependent*s (age 14 and under) fluoride once every twelve (12) months.
8. Sealants for Eligible Covered *Dependent*s (age 14 and under) once per 1st and 2nd permanent molar once per tooth per lifetime.
9. Space maintainers (ADA Codes 1510, 1515, 1520, 1525) for Eligible Covered *Dependent*s (age 14 and under) once per lifetime per space.
10. Periodontal scaling and root planning (ADA Codes 4341 and 4342) is limited to once per quadrant every twenty-four (24) months. In order to receive benefits, the Covered Person must submit to Denex Dental, ***before treatment***, a copy of the periodontal chart for pre-authorization for documented periodontal disease which

must include at least four (4) teeth per quadrant with 4 millimeters or greater periodontal pockets.

11. Periodontal maintenance (ADA Code 4910) limited to two per twelve (12) month period following active periodontal treatment (excluding gross debridement – ADA Code 4355).
12. Full mouth gross debridement (ADA Code 4355) limited to once per thirty six (36) months.
13. Resin based composites of posterior teeth (ADA Codes 2391 to 2394) will be paid at the rate for Amalgams. The Covered Person is responsible for any difference in fees charged by the Provider.
14. Amalgams and Composites (ADA Codes 2140 to 2394) one restoration allowed per surface every thirty six (36) months.
15. Dentures, Bridges, Crowns (per tooth) are limited to once every seven (7) years.
16. Root canals (ADA Codes 3310, 3320, 3330) once per tooth per lifetime. Re-treatment of root canal is limited to not more than once in twenty four (24) months for the same tooth.
17. Post and Cores (ADA Codes 2952 and 2954) will be covered only for teeth that have had root canal therapy.
18. Gingivectomy/gingivoplasty and osseous surgery (ADA Codes 4210, 4211, 4260, 4261) once per quadrant per thirty-six (36) month period.
19. Retreatments, Relines, Rebases, Replacements, or Repairs are excluded within six (6) months of the completion of the initial procedure. Benefits for denture repair will be limited to no more than half the cost of the Provider fee for a new denture.
20. Relines and rebases of existing removable dentures no more than once per thirty-six (36) month period.
21. Interim complete dentures (ADA Codes 5810, 5811) and interim partial dentures (ADA Codes 5820, 5821) may not be replaced for a twelve (12) month period.

22. Deep sedation (ADA Codes 9220, 9221) must be performed by an Oral Surgeon.
23. Examination, evaluation and treatment of temporomandibular joint (TMJ) pain dysfunction are excluded.
24. Replacement of all teeth and acrylic on cast metal framework (ADA Codes 5670, 5671) limited to once per thirty-six (36) month period.
25. Palliative treatment (ADA Code 9110) will be covered as a separate benefit only if no other service other than exam and radiographs were done during the visit.
26. Internal bleaching of a tooth (ADA Code 9974) will only be covered if the tooth had root canal treatment.
27. Dental procedures begun prior to the Covered Person's effective date of coverage are excluded for twelve (12) months following the Covered Person's effective date. Examples include, but are not limited to, teeth prepared for crowns, root canal therapy in progress. This exclusion does not apply to Diagnostic & Preventive Services.
28. Replacement of missing natural teeth, lost prior to the Covered Person's effective date, are excluded for twelve months following the Covered Person's effective date.
29. *Hospitali*zation for any dental procedure is excluded.
30. Drugs obtainable with or without a prescription are excluded.
31. Where two or more professionally acceptable dental treatments for a dental condition exist, the Plan bases reimbursement on the least costly treatment alternative.
32. Any bill, or demand for payment, for a dental service that the appropriate regulatory board determines were provided as a result of a prohibited referral. "Prohibited referral" means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.

OPTICAL BENEFITS

Benefits are through a closed network provider, "VSP"

*Participant*s and Eligible *Dependent*s in Plans 1, 2, 3 and 4.

Vision benefits are provided through VSP. Benefits include an eye exam, lenses, and contact lenses as described below. You should use a VSP network doctor to obtain the maximum benefit.

Covered Expenses

The following services are covered through your vision benefit at no cost to you:

1. An eye exam every 24 months (based on your last date of service).
2. Lined single vision, lined bifocal, and lined trifocal lenses covered every 24 months (based on your last date of service).
3. Frames. You may choose from a wide variety of covered frames every 24 months (based on your last date of service).
4. Contact lenses. Contact lenses are provided **in lieu of glasses** once every 24 months (based on your last date of service). The Plan will provide up to $105 toward the cost of the contacts. If you choose contacts, the Plan includes a 15% discount off the cost of your contact lens exam (fitting and evaluation) if you use a VSP network doctor.

If You Don't Use A VSP Provider

If you do not use a VSP network doctor, benefits are provided, but at a reduced rate. Services are covered as follows:

1. Eye exam every 24 months (based on your last date of service), reimbursed up to $46.
2. Lined single vision, lined bifocal, and lined trifocal lenses every 24 months (based on your last date of service), reimbursed up to $55 for lined single lenses, $75 for lined bifocal lenses, or $95 for lined trifocal lenses.
3. Frames every 24 months (based on your last date of service) reimbursed up to $45.

4. Contact lenses in lieu of glasses, once every 24 months (based on your last date of service) reimbursed up to $105. If the contacts are medically necessary, you may be reimbursed up to $210.

Laser Vision Correction

Laser vision correction (PRK, LASIK and Custom LASIK) is not covered, however discounts are available if the procedure is performed through contracted laser centers. No discount is available if you use a non-VSP provider. Contact VSP Member Services at (800) 877-7195 for specific information on how to receive a discount on this service.

How to Find A VSP Provider

To find a participating VSP provider, call VSP Member Services (800) 877-7195 or go to the VSP website at www.vsp.com.

How to Use Your Benefits

1. Call your VSP network doctor and make an appointment.
2. Tell the doctor you are a VSP *Participant* and give the provider your name and the *Participant*'s name and date of birth.
3. Tell the provider you are a Bakers *Union* & FELRA Health and Welfare *Fund Participant*.
4. Make your appointment.

There are no claim forms to file.

Reimbursement If You Used a Non-VSP Provider

If you used a non-VSP provider, you must pay for your services in full and request reimbursement. Send the itemized bill which shows a detailed description of the services provided and their cost and a completed Reimbursement Request Form. You may call VSP Member Services to request the Reimbursement Form or print the form from the VSP website (www.vsp.com).

Claims must be filed with VSP within 180 days from the date of service. Keep a copy of the information for your records and send the original to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Complaints and Grievances

*Participant*s or *Dependent*s should report any complaints and/or grievances to VSP at the address shown above. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to VSP verbally or in writing. You may submit written comments or supporting documentation concerning your complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify you or your *Dependent* of the expected resolution date. Upon final resolution, VSP will notify you or your *Dependent* of the outcome in writing.

Claims Filing and Review

If, under the terms of this Plan, a claim is denied in whole or in part, a request may be submitted to VSP by the covered person or covered person's authorized representative for a full review of the denial. “Covered Person” may designate any person, including his/her provider, as his/her authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal

The request must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the Covered Person for whom the claim was denied, including the VSP Enrollee's name, the VSP Enrollee's Member Identification Number, the Covered Person's name and date of birth, the provider of services and the claim number. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person as follows:

1. Prior Authorization for Visually Necessary or Appropriate Services: within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.
2. Denied Claims for Services Rendered: within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

Second Level Appeal

If the Covered Person disagrees with the response to the initial appeal of the claim, the Covered Person has a right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, the Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to the Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies: When the Covered Person has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation. The Covered Person may contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA Section 502(a)(l)(B), the Covered Person has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and the Covered Person disagrees with the outcome

Time of Action

No action in law or in equity shall be brought to recover from the Plan prior to the Covered Person exhausting his grievance rights as described in this section and the preceding sections and/or prior to the expiration of sixty (60) days after the claim and any applicable invoices have been filed with VSP. No such action shall be brought after the expiration of six (6) years from the last date that the claim and any applicable invoices may be submitted to VSP, in accordance with the terms of this Plan.

ADMINISTRATIVE PROCEDURES

Claims Filing And Appeals Procedures

Notice of Privacy Practices

Your Rights under ERISA

Telephone Numbers and Addresses

CLAIMS FILING AND APPEALS PROCEDURES

The Bakers Union and FELRA Health and Welfare Fund will comply with the claims and appeals procedures that apply to non-grandfathered health plans under the Affordable Care Act (ACA), including the ACA's requirement that for certain claims, after the Fund's internal appeals processes are exhausted, the *Participant* can ask for an external review by an independent external review organization, known as an independent Review Organization (IRO). The decision of the IRO will be binding on the Fund. A copy of the Fund's full claims and appeals process follows in this section.

The rules below are general rules for filing claims for all benefits. For more specific information, see the claims filing information in each individual benefit section. The section below summarizes general rules which apply to **ALL** claims for benefits under the Plan.

When You File a Claim

1. When you see a *Physician* or go to the *Hospital*, show your *Fund* ID card.
2. The provider may submit a bill directly to the Bakers Union & FELRA Health and Welfare Fund provided you have signed an "Assignment of Benefits" authorizing the *Fund* to make payment directly to the provider.
3. You (or the provider on your behalf) must submit an itemized bill or file a claim using a claim form to be eligible for benefits.
4. **Claims for benefits must be filed within two years (730 days) from the date of service, within two years from the date the disability began (for Weekly Accident and Sickness benefits) or within 20 days (or as soon as reasonably possible) from the date of *Injury* or death for Accidental Death and Dismemberment and Life Insurance claims.**
5. If your provider or *Hospital* has not billed the *Fund* directly, you must submit an itemized bill from the provider to the *Fund Office*.

6. Requests for additional information from the *Fund Office* must be returned within two weeks from the date the request was mailed to you. If you fail to supply the requested information within the two week limit, the *Fund* will deny the claim. However, if the requested information is submitted within the original two year filing timeframe, the claim will be re-opened and processed at that time.
7. The fact that a claim from another source has been filed or may be pending does not excuse you from the claims filing requirements. Lack of knowledge of these requirements or coverage does not excuse you or your covered *Dependent* from them.
8. You will receive an Explanation of Benefits ("EOB") from the *Fund Office* when your claim has been processed. Please keep the EOB and refer to it when you have questions about your claim and how it was processed.
9. Keep copies of any bills you submit to the *Fund* for your records. Original bills will not be returned to you.
10. Benefit payments will be sent directly to the provider unless they are unassigned and there is evidence on the bill that you paid the provider yourself.
11. The Board of *Trustees* may, at the *Fund's* own expense, request that the person making a claim for benefits be examined as often as reasonable during the pendency of a claim

Time Frame for Claims Processing

As stated above, the time frame for filing a claim is two years from the date of service or from the date the disability began or the *Injury* took place.

Claim Processing and Review

Claims for vision benefits are provided under insurance agreements between the *Fund* and specific insurers. However, because the *Fund* is still responsible for determining your eligibility for vision benefits, you may follow the appeal procedures provided below for vision appeals for eligibility denials.

You may name a representative to act on your behalf during the claims procedure. To do so, you must notify the *Fund* in writing of the representative's name, address, and telephone number and authorize the *Fund* to release information (which may include medical information) to your representative. Please contact the *Fund Office* for a form to designate a representative. In the case of an Urgent Care claim, defined below, a health care professional with knowledge of your medical condition will be permitted to act as your representative. The *Fund* does not impose any charges or costs to review a claim or appeal; however, regardless of the outcome of an appeal, neither the Board of *Trustees* nor the *Fund* will be responsible for paying any expenses that you might incur during the course of an appeal.

The *Fund* and Board of *Trustees*, in making decisions on claims and on appeal, will apply the terms of the Plan and any applicable guidelines, rules and schedules, and will periodically verify that benefit determinations are made in accordance with such documents, and where appropriate, applied consistently with respect to similarly situated claimants. Additionally, the *Fund* and *Trustees* will take into account all information you submit in making decisions on claims and on appeal.

With respect to any claim relating to medical, *Hospital*, prescription, mental health and substance abuse and dental benefits, if the *Fund* denies the claim, in whole or in part, the *Fund* will send you a written notice of the denial, unless, as noted above, your claim is for Urgent Care, in which case this notice may be oral, followed in writing. The notice will provide:

1. the specific reason or reasons for denial;
2. reference to specific Plan provisions on which the denial is based;
3. a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

4. an explanation of the Plan's claims review procedures and the time limits applicable to such procedures, including the expedited review process applicable to Urgent Care claims;
5. a statement of the your right to bring a civil action under Section 502(a) of ERISA following a denial of your appeal;
6. if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim, a statement that the specific rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and
7. if the denial is based on a determination of medical necessity or *Experimental Treatment* or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment related to your condition will be provided free of charge upon request.

If your claim is denied, in whole or in part, you are not required to appeal the decision. However, before you can file suit under Section 502(a) of the Employee Retirement Income Security Act ("*ERISA*") on your claim for benefits, you must exhaust your administrative remedies by appealing the denial to the Board of *Trustees*. Failure to exhaust these administrative remedies will result in the loss of your right to file suit. If you wish to file suit for a denial of a claim for benefits, you must do so within three years of the date the *Trustees* denied your appeal. For all other actions, you must file suit within three years of the date on which the violation of Plan terms is alleged to have occurred. Additionally, if you wish to file suit against the Plan or the *Trustees*, you must file suit in the United States District Court for the District of Maryland. These rules apply to you, your spouse, *Dependent*, alternate payee or beneficiary, and any provider who provided services to you or your spouse, *Dependent* or beneficiary. The above paragraph applies to all litigation against the *Fund*, including litigation in which the *Fund* is named as a third party defendant.

The *Fund's* procedures and time limits for processing claims and for deciding appeals will vary depending upon the type of claim, as explained below. However, the *Fund* may also request that you voluntarily extend the period of time for the *Fund* to make a decision on your claim or your appeal.

Medical Benefit Claim Review

1. Pre-Service Claim You are required to obtain pre-certification from CareAllies before an elective or non-emergency *Hospital*ization. If your pre-service claim is filed improperly, the *Fund* will notify you of the problem (either orally or in writing, unless you request it in writing) within five (5) days of the date you filed the claim. The *Fund* will notify you of its decision on your pre-service claim (whether approved or denied) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after the claim is received by the *Fund*. CareAllies has the same fifteen day period to make its pre-authorization decision. The *Fund* may extend the period for a decision for up to fifteen (15) additional days due to matters beyond the control of the *Fund*, provided that the *Fund* gives you a written notice of such extension before the end of the initial fifteen (15) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the *Fund* expects to make a decision. If an extension is necessary due to your failure to submit the information required to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least forty-five (45) days from receipt of the notice to provide the requested information.

If you do not provide the information requested, or do not properly re-file the claim, the *Fund* will decide the claim based on the information it has available, and your claim may be denied.

2. Urgent Care Claim It is important to note that the rules for an Urgent Care claim apply only when the Plan requires approval of

the benefit *before* you receive the services; these rules do not apply if approval is not required before health care is provided, for example in the case of an emergency.

If your Urgent Care claim is filed improperly, the *Fund* will notify you of the problem (either orally or in writing, unless you request it in writing) within 24 hours of the date you filed the claim. The *Fund* will notify you of the decision on your Urgent Care claim (whether approved or denied) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the claim is received by the *Fund*, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. If the *Fund* needs more information, the *Fund* will notify you of the specific information necessary to complete the claim as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the *Fund*. You will be given a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the requested information. The *Fund* will notify you of its decision as soon as possible, but not later than forty-eight (48) hours after the earlier of (i) the *Fund's* receipt of the specified information or (ii) the end of the period given to you to provide the specified information. Due to the nature of an Urgent Care claim, you may be notified of a decision by telephone, which will be followed by a written notice of the same information within three (3) days of the oral notice.

If you do not provide the information requested, or do not properly refile the claim, the *Fund* will have to decide the claim based on the information it has available, and your claim may be denied.

3. Concurrent Care Claim If you have been approved by the *Fund* for Concurrent Care treatment, any reduction or termination of such treatment (other than by Plan amendment or termination of the Plan) before the end of the period of time or number of treatments will be considered denial of a claim. The *Fund* will notify you of the denial of the claim at a time sufficiently in advance

of the reduction or termination to allow you to appeal and obtain a decision on review of the denial of the claim before the benefit is reduced or terminated.

Your request to extend a course of treatment beyond the previously approved period of time or number of treatments that constitutes an Urgent Care claim will be decided as soon as possible, taking into account medical circumstances, and will be subject to the rules for Urgent Care claims (see above), except the *Fund* will notify you of the decision (whether approved or denied) within twenty-four (24) hours after the *Fund's* receipt of the claim, provided that the claim is made to the *Fund* at least twenty-four (24) hours before the end of the previously approved period of time or number of treatments.

4. Post-Service Claim If the *Fund* denies your post-service claim, in whole or in part, the *Fund* will send you a notice of the claim denial within a reasonable period of time, but not later than thirty (30) days after the claim is received by the *Fund*. The *Fund* may extend the period for a decision for up to fifteen (15) additional days due to matters beyond the control of the *Fund*, provided that the *Fund* gives you a written notice of such extension before the end of the initial thirty (30) day period. The notice of an extension will set forth the circumstances requiring an extension of time and the date by which the *Fund* expects to make a decision. If your post-service claim is incomplete, the *Fund* will deny the claim within the 30 day period mentioned above. You may resubmit the claim, with the necessary additional information, at any time within two years from the date of service.

If Your Claim Is Denied -- Appeal Procedures

If you receive a notice that your claim for benefits has been denied, you may request the Board of *Trustees* to review the denied claim within 180 days of the receipt of the Notice of Denial. If you have not received a decision on a claim for benefits within 90 days (180 days in special circumstances), you may request a review of your claim. You or your authorized

representative may request a review, and, upon request, you will be provided reasonable access to and copies of documents, records or other information relevant to your claim, without regard to whether such documents, records and information were considered or relied upon in making the adverse benefit determination that is the subject of the appeal. You may submit issues and comments in writing to the *Fund Office*.

The Board of *Trustees* will make a decision on your appeal at its next regularly scheduled meeting or, if the request is received fewer than 30 days before that meeting, at the following regularly scheduled meeting. In special circumstances, the decision may be made at the third regularly scheduled meeting following receipt of your request, but in this event you will be notified of the delay and will be given an estimated date by which a decision is expected. The decision of the Board will be in writing and will include the reasons for the decision and specific references to plan provisions on which the decision is based. The decision of the Board will be final and binding on all parties, subject to your rights under ERISA.

Review of a Denied Claim

You have the right to appeal a denial of your benefit claim to the *Fund's* Board of *Trustees*. Your appeal must be in writing and must be sent to the Board of *Trustees* at the following address:

Bakers Union & FELRA Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

Your appeal of an Urgent Care claim (as defined on page 150) may also be made by telephone by calling toll free 1-866-662-2537 or by faxing a letter to 1-877-227-3536.

If your claim is denied, you (or your authorized representative) may, within 180 days from receipt of the denial, request a review by writing to the Board of *Trustees*. Pursuant to your right to appeal, you will have the right (a) to submit written comments,

documents, records, and other information relating to your claim for benefits; and (b) upon request, reasonable access to, and free copies of, all documents, records, and other information relevant to your claim for benefits. In making a decision on review, the Board of *Trustees* or a committee of the Board of *Trustees* will review and consider all comments, documents, records, and all other information submitted by you or your duly authorized representative, without regard to whether such information was submitted or considered in the initial claim determination. In reviewing your claim, the Board of *Trustees* will not automatically presume that the *Fund's* initial decision was correct, but will independently review your appeal. In addition, if the initial decision was based in whole or in part on a medical judgment (including a determination whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the Board of *Trustees* will consult with a healthcare professional in the appropriate medical field who was not the person consulted in the initial claim (nor a subordinate of such person) and will identify the medical or vocational experts who provided advice to the *Fund* on the initial claim.

In the case of an appeal of a claim involving Urgent Care as defined above, the Board of *Trustees* will notify you of the decision on your appeal as soon as possible, taking into account the applicable medical exigencies, but not later than seventy-two (72) hours after the *Fund's* receipt of your appeal. In the case of an appeal of a pre-service claim, the Board of *Trustees* will notify you of the decision on your appeal within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after the *Fund's* receipt of your appeal. The *Fund* may also request that you voluntarily extend the period of time for the Board of *Trustees* to make a decision on your appeal.

In the case of an appeal of a post-service claim, the Board of *Trustees* or a committee of the Board of *Trustees* will hear your appeal at its next scheduled quarterly meeting following receipt

of your appeal, unless your appeal was received by the *Fund* within 30 days of the date of the meeting. In that case, your appeal will be reviewed at the second quarterly meeting following receipt of the appeal. If special circumstances require an extension of the time for review by the *Trustees*, you will be notified in writing, before the extension, of the circumstances and the date on which a decision is expected. In no event will a decision be made later than the third quarterly meeting after receipt of your appeal. The *Trustees* will send you a written notice of their decision (whether approved or denied) within 5 days of the decision.

The denial notice will provide (a) the specific reason or reasons for the denial; (b) references to specific Plan provisions on which the denial is based; (c) 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 your claim for benefits; and (d) a statement of your right to bring an action under Section 502(a) of ERISA. In addition, the notice will state that (a) if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your appeal, a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge upon request; and (b) if the denial of your appeal was based on a medical necessity or *Experimental Treatment* or similar exclusion or limit, an explanation will be provided free of charge upon request.

The Board of *Trustees* has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan. The decision of the Board of *Trustees* is final and binding.

External Review of Claims for Uninsured Benefits – Comprehensive Medical and Prescription Drug

If your claim for uninsured benefits has been denied and if you have exhausted the *Fund*'s internal claims and appeal procedures as

described above, you may be entitled to appeal the decision to an external independent review organization ("IRO"). External review is limited to claims involving medical judgment (e.g., lack of *Medical Necessity*, or a determination that a claim is *Experimental* or cosmetic) or a retroactive rescission of coverage. No other denials will be reviewed by an IRO unless otherwise required by law.

A request for external review must be filed with the *Fund Office* within four months after you receive notice of the denial of your appeal (or if earlier, by the first day of the fifth month after receipt of the decision on your appeal).

Preliminary Review. Within five business days of receiving your request for an external review, the *Fund* will complete a preliminary review of your request to determine whether it is eligible for external review (e.g., whether you have exhausted the *Fund*'s claims and appeals procedures and provided all the necessary information).

Within one business day after the preliminary review is completed, you will be notified whether the claim is eligible for external review, except that to the extent required by law, the preliminary review may be referred to an IRO to determine whether the claim involves medical judgment. If your external review request is complete but your claim is not eligible for external review, you will receive a notice stating the reason(s) it is not eligible, and you will receive contact information for the Employee Benefits Security Administration. If your external review request is not complete, the notice will describe the information or materials needed to make your request complete. You may submit additional required information within the original four-month filing period or within the 48-hour period following your receipt of the decision regarding your eligibility for external review, whichever is later.

Referral to Independent Review Organization. If your external review request is complete and your claim is eligible for external review, the *Fund* will forward your claim to an IRO for review. The

IRO will notify you in writing that your claim has been accepted for external review.

You are permitted to submit in writing to the assigned IRO, within ten business days following the date you receive the initial notice from the IRO, additional information that you want the IRO to consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after ten business days. If you choose to submit such information, within one business day, the assigned IRO will forward the information to the *Fund*. Upon receipt of any such information, your claim that is subject to external review may be reconsidered. Reconsideration will not delay the external review. The external review may be terminated as a result of the reconsideration only if the *Fund* decides, upon completion of its reconsideration, to reverse its denial and provide payment. Within one business day after making such a decision, you and the assigned IRO will receive written notice of the decision. Upon receipt of such notice, the assigned IRO will terminate the external review.

In making its decision, the IRO will review all of the information and documents it timely receives, and will not be bound by any decisions or conclusions reached during the *Fund*'s internal claims and appeals process. In addition, the IRO may consider additional information relating to your claim to the extent the information is available and the IRO considers it to be relevant.

The IRO will provide you with written notice of its decision within 45 days after it receives the request for review. The IRO's decision notice will contain:

- A general description of the claim and the reason for the external review request;
- The date the IRO received the external review assignment and the date of its decision;
- Reference to the evidence considered in reaching its decision;

- A discussion of the principal reason(s) for its decision, and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law;
- A statement that judicial review may be available to you; and
- Contact information for any applicable consumer assistance office.

Upon request, the IRO will make available to you its records relating to your request for external review, unless such disclosure would violate state or federal privacy laws.

Reversal of the Fund's decision. If the IRO issues a final decision that reverses the *Fund*'s decision, the *Fund* will pay the claim.

Expedited External Review of Denied Claims. You may request an expedited external review of an urgent care claim denial, or of an appeal denial involving an emergency admission, continued stay, or emergency service, if the claimant has not yet been discharged from the facility. You may request an expedited external review at the same time an appeal is submitted to the *Fund*'s Board of *Trustees*, if the claimant requires urgent care or is receiving an on-going course of treatment.

Immediately upon receiving your request for expedited external review, a determination will be made as to whether your request is eligible for external review as described above. The *Fund* will immediately send you a notice of its eligibility determination.

If your claim is determined to be subject to external review, the IRO will provide a decision as soon as possible under the circumstances but no more than 72 hours after receiving the expedited request for review.

For certain benefits, before filing an appeal with the Board of *Trustees* as described above, you may wish to contact the appropriate *Fund* provider identified below with any questions or concerns that you have regarding the claim denial. If you choose to do so, please contact the provider directly for important information regarding the appropriate procedures, including any time limits.

Whether or not you choose to address your concerns to the provider, you have the right to appeal a benefit denial to the Board of *Trustees* as described above. However, if you choose to address your concerns to the provider, you must do so before you appeal to the Board of *Trustees* and, if you are not satisfied with the results through the provider and wish to file an appeal to the Board of *Trustees*, you must do so within 180 days from the day you received the claim denial from the *Fund Office* or other *Fund* provider. If you do not choose to address your concerns to the provider and wish to appeal directly to the Board of *Trustees*, you must do so within 180 days from the day you received the claim denial from the *Fund Office*. Please remember that if you are not able to resolve your concerns by contacting the appropriate provider named below, you must appeal to the Board of *Trustees* before filing a suit against the *Fund*.

- For certification denials made by CareAllies, you may contact CareAllies.
- For denials by Vision Service Plan ("VSP"), you may contact VSP at the address shown on page 142.
- For denials by Denex Dental ("Denex"), you may contact Denex at the address shown on page 134.
- For prescription drug denials by Optum Rx, you must appeal to the Board of *Trustees* (there is no internal appeal process under Optum).

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls

- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
We can share health information about you with organ procurement organizations.

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site at www.associated-admin.com and we will mail a copy to you.

Date of Notice: November 2013

HIPAA Privacy Officer

Bakers *Union* and FELRA Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
(866) 662-2537

YOUR RIGHTS UNDER ERISA

As a *Participant* in the Bakers Union and FELRA Health & Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan *Participant*s shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and *Union* halls, all documents governing the plan, including insurance contracts and *Collective Bargaining Agreements*, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and *Collective Bargaining Agreements*, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each *Participant* with a copy of this summary annual report.

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect *COBRA* continuation coverage, when your *COBRA* continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan *Participant*s, 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 *Participant*s and beneficiaries. No one, including your *Employer*, your *Union*, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control

of the administrator. if you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

TELEPHONE NUMBERS AND WEBSITES

Fund Office
911 Ridgebrook Road
Sparks, MD 21152-9451 **(866) 662-2537**
www.associated-admin.com

Cigna HealthCare **(800) 768-4695**
www.Cignasharedadministration.com

Cigna HealthCare PPO Address for Claims
P.O. Box 936
Frederick, MD 21705-0936

CareAllies **(800) 768-4695**
www.myCareAllies.com

24-Hour NurseLine **(800) 768-4695**
www.myCareAllies.com

Briova Rx Ascend **(855) 427-4682**
(Specialty medications)

OptumRx **(888) 869-4600**
www.optumrx.com/myCatamaranRx

Denex Dental **(866) 433-6391**
www.DenexDentalcom

Vision Service Plan (VSP) **(800) 877-7105**
www.vsp.com

LabCorp Laboratories **(888) 522-2677**
www.labcorp.com

Quest Laboratories **(800) 377-7220**
www.questdiagnostics.com