Group Benefit Plan

provided by:

Plumbing and Pipefitting Industry Health and Welfare Fund of Kansas

Administered by

Plumbing and Pipefitting Industry Health and Welfare Fund of Kansas

Aetna

and

Delta Dental of Kansas, Inc.

August 1, 2023

Plumbing and Pipefitting Industry Health and Welfare Plan of Kansas

August 2023

To Our Members:

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

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

We are proud of the Plan, and know that you will share in our pride. You should carefully study this booklet and keep it for future reference. If you have any questions, do not hesitate to contact the Plan Administrator at 529 S Anna Street, Suite B, Wichita, Kansas 67209, Phone (316) 264-2339.

Very truly yours,

Employer Trustees

Union Trustees

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

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

- Aetna administers the Health Care Benefits. Claims for Health Care Benefits should be filed with Aetna. Although Health Care Benefits are paid from the Trust Fund, the Trust Fund has entered into a contract with an insurer that provides stop-loss coverage to shield the Trust Fund from unexpectedly high claims expenses.

- Delta Dental of Kansas ("Delta Dental"), a nonprofit dental service corporation, administers the Dental Benefits. Claims for dental benefits should be filed with Delta Dental. Dental Benefits are paid from the Trust Fund, and Delta Dental is not the insurer of these benefits.

- The Trustees of the Trust Fund administer all other benefits under the Plan. Claims for these benefits should be filed with the Plan Administrator.

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

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

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

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

IMPORTANT

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

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

ALL CLAIMS PAID ARE A COST OF THE TRUST FUND.

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PART I

GENERAL INFORMATION AND ELIGIBILITY RULES

ELIGIBILITY RULES

Employees

All employees working for an employer that is required by a collective bargaining agreement to make contributions to the Trust Fund, or for an employer within the geographical jurisdiction of the bargaining agreement establishing and maintaining the Fund, as well as certain employees of Local 441 of the United Association of Plumbers and Pipefitters (the "Union"), certain employees of the Joint Apprenticeship Committee, and employees of Benefits Management Group, Inc. ("BMGI") who are employed at BMGI's Wichita, Kansas office and who are identified in a participation agreement entered into between BMGI and the Fund, shall be eligible to receive benefits, after meeting the eligibility requirements described below.

Initial Eligibility

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

In the case of an employee who is hired on or after July 25, 2022, by an employer that elects to pre-pay the employee's initial qualifying work period, the 3-month work requirement will be waived, and eligibility will begin the first day of the month following the date the employer pre-pays the equivalent of 450 hours of contributions on behalf of the employee. Such an employee will receive an opening balance in his or her Dollar Bank equal to 450 hours multiplied by the current contribution rate.

In the case of an employee who is hired by an employer on or after May 1, 2023, and before May 1, 2024, eligibility will begin the first day of the month, coincident with or next following his or her date of hire. Such an employee will receive an opening balance in his or her Dollar Bank equal to 280 hours multiplied by the current contribution rate.

Special eligibility rules apply to employees working for employers in a collective bargaining unit newly organized by the Union. Employees working for employers organized before April 1, 2022, will be eligible for coverage on the first day of the first month following a qualifying work period, which may be as short as a single month. Employees working for employers organized on or after April 1, 2022, will be eligible for coverage on the first day of the month coincident with or next following the date that the employer executes the collective bargaining agreement with the Union. An individual who is an employee of such an employer on the day the employer is organized will receive an opening balance in his or her Dollar Bank equal to 310 hours multiplied by the current contribution rate. These special rules will only apply if (1) the employee was a member of the collective bargaining unit on the day it was organized by the Union and (2) during at least the 30

days immediately before the effective date of the bargaining agreement that applies to that unit, the employer provided comprehensive medical care to employees in the unit.

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

If an employee acquires a newborn child, the newborn child will automatically be covered as of the newborn child's date of birth, but only if a copy of the newborn child's birth certificate is provided to the Plan Administrator within the first 91 days following the child's birth. If the newborn child's birth certificate is not submitted to the Plan Administrator by the end of the 91-day period, the newborn child's coverage will be terminated and claims incurred by the newborn child will not be paid. If the Plan Administrator receives a birth certificate within 365 days after the newborn child's birth and after the 91-day period has expired and coverage has been terminated, the newborn child's coverage will be reinstated retroactive to the date of termination, but only if the child has incurred any claims.

An employee's spouse will automatically be covered as of the date the employee and spouse are legally married, but only if a copy of their marriage license is provided to the Plan Administrator within 60 days after the date of marriage. If the marriage license is not submitted to the Plan Administrator by the end of the 60-day period, the spouse's coverage will be terminated and claims incurred by the spouse will not be paid. If the Plan Administrator receives a copy of the marriage license within 365 days after the date of marriage and after the 60-day period has expired and coverage has been terminated, the spouse's coverage will be reinstated retroactive to the date of termination, but only if the spouse has incurred any claims.

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

1. The first day of the first month in which you no longer have sufficient dollars credited to your Dollar Bank account to permit the Plan to maintain your coverage for that month;

2. The first day immediately following the date you cease to be either an employee or ready, willing and available for work for an employer in a collective bargaining unit represented by the Union;

3. The first day immediately following the date you cease to be a dependent;

4. The date you enter the armed forces on active duty;

5. The first day of the fourth calendar month after the calendar month in which the Plan Administrator provides notice to your or, in the case of a dependent, your sponsor's, contributing employer of its failure to comply with the Plan's requirements for posting a bond; or

6. The date the Plan is terminated.

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

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

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

Contributions for Shareholder Employees

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

Dollar Bank

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

Maintenance of Eligibility

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

1. You were working for the Union, BMGI, or a joint apprenticeship committee serving the plumbing and pipefitting industry;

2. You were working in a bargaining unit represented by the Union;

3. You were seeking work in a bargaining unit represented by the Union;

4. You were totally disabled; or

5. You had some combination of these.

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

Self-Contributions

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

Cancellation of Dollar Bank Balances

The balance in your Dollar Bank will be cancelled as of the last day of the 12th consecutive calendar month following the last day you worked for the Union, BMGI, a joint apprenticeship committee serving the plumbing and pipefitting industry, or in a bargaining unit represented by the Union, or were ready, willing and available for work for an employer in a collective bargaining unit represented by the Union.

Reinstatement of Eligibility

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

Notwithstanding the foregoing, an employee hired by an employer on or after May 1, 2023, and before May 1, 2024, who fails to remain eligible for benefits under the Plan will become eligible again on the first day of the second calendar month following a month during which he or she is credited with contributions in the amount of 140 pro-rated hours.

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

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

1. He or she applies for or returns to a position of employment with an employer who has an obligation to contribute to the Plan on his or her behalf, but only if he or she has reemployment rights protected by applicable federal law regarding uniformed service; and

2. He or she pays for such coverage as if it were COBRA continuation coverage, subject to the rules on the cost and duration of COBRA continuation coverage and the timing of payments set forth in the Section of this booklet titled **"Continuation of Coverage Under COBRA."**

Dependents

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

An **eligible child** is any person:

1. Who is the natural or adopted child of an employee;

2. Who:

   (a) has not reached the end of the month in which his or her 26th birthday occurs; or

   (b) is a disabled child.

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

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

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

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

Maternity Benefits

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

Qualified Medical Child Support Orders

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

Coverage for Dependents of a Deceased Employee

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

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

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

Continuation and Reinstatement of Coverage on Account of Qualified Uniformed Service

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

1. Persons Eligible for Continued Coverage. An employee who is absent from the employment of his or her employer on account of a period of Qualified Uniformed Service may elect to continue employee and dependent medical coverage on a self-pay basis or by making the special election provided in paragraph 3 of this Section, for the 24 month period beginning on the date on which the employee is first absent from employment by reason of Qualified Uniformed Service. Coverage will terminate on the earlier of the day after the date on which the employee fails to apply for or return to a position of employment, if the failure to apply or return terminates the employee's right to reemployment rights under applicable federal law regarding uniformed service, or when the grace period for making payments that are due, as described in paragraph 6 of this Section, expires.

2. Cost of Continued Coverage. The monthly charge for continued coverage will be determined by the Trustees, and will be the same for all similarly situated individuals electing the same type of coverage under this provision. If any single period of Qualified Uniformed Service is for a period of less than 31 days, the only amount required to be paid by the employee is the amount, if any, the employee would pay if he or she had not entered Qualified Uniformed Service. In other cases, the employee's charge will reflect both the employee's portion and the employer's portion, determined in the same manner as COBRA charges.

3. Election to Use Dollar Bank Balance. All or part of the monthly charge described in paragraph 2 of this Section may be avoided by the employee's election to use the balance in his or her Dollar Bank account to qualify for continuing coverage during his or her Qualified Uniformed Service until that balance is exhausted. See paragraph 7 of this Section.

4. Benefits Subject to Continuation. Any election made by an employee applies to the employee and the employee's dependents who otherwise would lose coverage under the Plan. No separate election may be made by any dependent. The medical coverage that employees are allowed to continue on behalf of themselves and their dependents will be the same as that provided to active employees and their dependents under the Plan. Except in connection with circumstances that permit other employees to make changes, an employee may continue only the type of coverage that he or she was receiving on the day before the employee first was absent from employment.

5. Election of Continued Coverage. An employee eligible to continue coverage under this provision will be sent an application for continued coverage within 30 days after the Plan Administrator receives notice, satisfactory to the Plan Administrator, that the employee will be, or is, absent from employment for a period of Qualified Uniformed Service. If an employee wishes to have coverage continued, he or she must complete the application and return it to the Plan Administrator within 60 days from the later of the date the application is sent or the date coverage otherwise would terminate.

6. Payment for Continued Coverage. The continuation of coverage is conditioned on an employee's payment of the monthly charges for the coverage, determined from the date coverage otherwise would terminate, even if the employee waits 60 days from that date to return the application. If an employee elects continued coverage, payment must be made, relating back to the date that coverage otherwise would terminate, within 45 days after the date the employee elects to continue coverage. After that, payments must be made by the first day of each month for which coverage is to be provided, subject to a 30-day grace period.

7. Reinstatement of Coverage. Special protections apply if, immediately following a period of Qualified Uniformed Service, an individual resumes service with a contributing employer and, during Qualified Uniformed Service, coverage under the Plan was terminated. In that case, and notwithstanding other Sections of this booklet, exclusions and waiting periods will be applied to the individual and his or her dependents only to the extent they would have applied if coverage had not been terminated as a result of Qualified Military Service. Exclusions and waiting periods will be applied, nonetheless, in the case of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The Section of this booklet titled **"Reinstatement of Eligibility"** contains additional rules regarding reinstatement rights.

8. Life Insurance, Accidental Death and Dismemberment, and Disability Benefits. These special rules for Qualified Uniformed Service apply to Health Care Benefits, Vision Benefits and Dental Benefits only. For purposes of applying the provisions of the Plan,

and of any applicable insurance policy, regarding the Plan's Life Insurance Benefit, Accidental Death and Dismemberment Benefit, and Weekly Disability Benefit, the rights and benefits of an employee who is absent from employment on account of a period of Qualified Uniformed Service shall be equivalent to those of an employee having similar seniority, status and pay who is on furlough or leave of absence for the period of Qualified Uniformed Service.

9. Qualified Uniformed Service. An absence from employment shall be considered "Qualified Uniformed Service" only if the following conditions are satisfied:

   (a) The service constitutes the performance of duty on a voluntary or involuntary basis under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard Duty, and a period for which an employee is absent from employment for the purpose of an examination to determine the fitness of the employee to perform any such duty.

   (b) The service is in one of the "uniformed services." "Uniformed services" means the Armed Forces of the United States, the Army National Guard and the Air National Guard when engaged in active duty for training or inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

   (c) The employee had coverage under the Plan at the time his or her service began.

   (d) The period of service does not exceed 60 months or such other period as may be required by applicable law.

10. Election by Family Members, Other Personal Representatives. When the Plan Administrator determines that it is appropriate under the circumstances, any election required to be made by an employee under this Section while the employee is engaged in a period of Qualified Uniformed Service may be made by one of the employee's family members or a personal representative. Any such election shall be binding on the employee and any dependents to whom it pertains.

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

Continuation of Coverage Under the Family and Medical Leave Act

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

Continuation of Coverage Under COBRA

Apart from the rights to continued Plan coverage described in the preceding Sections, you may be entitled to continue certain aspects of your Plan coverage as provided in this Section. It contains

important information about your right to COBRA coverage, which is a temporary extension of coverage under the Plan. This Section also contains information about other coverage alternatives that may be available to you through the Health Insurance Marketplace.

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

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

1. Qualified Beneficiaries. The Plan offers COBRA coverage to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Specific qualifying events are listed below. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA coverage must pay for it. An individual is also eligible to elect COBRA coverage if:

   (a) He or she is a child born to, adopted by, or placed for adoption with an employee or former employee while the employee or former employee is receiving COBRA coverage; or

   (b) His or her coverage under the Plan is reduced or eliminated in anticipation of a qualifying event.

   In the case of subparagraph (a), above, so long as newborn or newly adopted children elect COBRA coverage within 60 days of their birth or adoption, they will enjoy an independent right to maintain their COBRA coverage in the event that the employee or former employee drops his or her own COBRA coverage before the end of the maximum coverage continuation period.

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

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

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

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

(a) The termination of the employee's employment; or

(b) A reduction in the employee's work hours below the minimum needed to maintain his or her dependents' eligibility under the Plan.

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

(a) The death of the employee;

(b) The termination of the employee's employment;

(c) A reduction in the employee's work hours below the minimum needed to maintain his or her dependents' eligibility under the Plan; or

(d) The divorce of the employee.

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

(a) The death of the employee;

(b) The termination of the employee's employment;

(c) A reduction in the employee's work hours below the minimum needed to maintain his or her dependents' eligibility under the Plan;

(d) The divorce of the employee; or

(e) The child's ceasing to qualify as an "eligible child" under the Plan.

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

3. Coverage Continuation Periods. If an employee and his or her dependents would lose coverage because of his or her termination of employment or reduction in work hours, the employee and his or her dependents may apply for continuation of either "Medical" coverage or "Full" Plan coverage for up to 18 months after coverage would otherwise be lost. A special rule applies if an employee becomes entitled to Medicare within 18 months prior to the loss of coverage as a result of termination of employment or reduction in work hours. In such a case, the employee's loss of coverage will entitle his dependents to continuation coverage that extends until the later of (a) 18 months after coverage would

otherwise be lost, or (b) 36 months after the employee's Medicare entitlement. If the employee's dependents would lose coverage as a result of the employee's death, divorce or a child's ceasing to be an "eligible child" under the Plan, those dependents may apply for continuation of coverage for up to 36 months.

4. Successive Qualifying Events. If an employee's dependents elect continued coverage following the employee's termination of employment or reduction in work hours, and then a second qualifying event that would otherwise entitle the employee's dependents to 36 months of continued coverage occurs during that continuation period, those dependents may elect to continue their coverage for up to 36 months, rather than only 18 months. This 36-month period will be determined by adding an additional 18 months to the original 18-month period. Should this situation arise, dependents will be given another opportunity to elect or decline continued coverage for the remainder of the 36-month period. In order to be eligible for extended coverage under this paragraph, an individual must be eligible to elect COBRA coverage under the provisions described above at the time of the second qualifying event. A qualified beneficiary (or his or her representative) must notify the Plan Administrator within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator, at the address shown in the Section of this booklet titled **"Information About the Plan."**

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

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

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

6. Coverage of Newborn and Newly Adopted Children. A child born to, adopted by, or placed for adoption with a former employee while the former employee is receiving COBRA coverage will be allowed to enroll in COBRA coverage as well. Thus, so long as proper notice of the birth or adoption is provided to the Plan Administrator, a former employee will be allowed to add any newborn or newly adopted child to that individual's COBRA coverage immediately upon the child's birth or adoption.

7. Notification Requirements. It will be the obligation of the employee, former employee or dependent to notify the Plan Administrator within 60 days of any divorce, child's birth, adoption or placement for adoption, or a child's ceasing to be an "eligible child" under the terms of the Plan. This notice must be sent to the Plan Administrator at the Plan Administrator's address, which is set forth in the Section of this booklet titled **"Information About the Plan."** If such timely notice is not received, continuation coverage will not be available with respect to that event.

8. Cost of COBRA Continuation Coverage. The monthly charge for continued coverage will be determined by the Trustees, and will be the same for all similarly situated individuals electing the same type of coverage under this provision. In their discretion, however, the Trustees may require smaller monthly payments by former employees who are actively seeking work in a bargaining unit represented by the Union than by other former employees.

9. Benefits Subject to Continuation. The coverage that employees and their dependents are entitled to continue will be the same as that provided to employees and their dependents under the Plan. If an employee or his dependents choose to continue coverage under this Section, that individual or individuals will be entitled to the Plan's Health Care Benefits, Death Benefits, Accidental Death and Dismemberment Benefits, Weekly Disability Benefits, Vision Benefits, and Dental Benefits. Because only employees are eligible for the Plan's Death Benefits, Accidental Death and Dismemberment Benefits, and Weekly Disability Benefits, dependents are not entitled to continue any of those benefits.

10. Election of COBRA Coverage. An individual eligible to continue his or her coverage under COBRA will be sent an application for continued coverage within 30 days after the Plan Administrator is notified of a qualifying event. If that individual wishes to continue his or her coverage, he or she must complete the application and return it within 60 days from the later of the date it is sent to the individual or the date his or her coverage would otherwise terminate.

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

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

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

(a) If a required payment is not made before the end of the 30-day grace period described above; or

(b) If, after an individual elects continued coverage, he or she becomes covered under another employer group health plan (as an employee or otherwise); or

(c) If, after an individual elects continued coverage, he or she becomes entitled to Medicare benefits; or

(d) If the last employer to contribute to the Plan on behalf of the individual ceases to be required to contribute to the Plan and either:

(i) makes group health plan coverage available to a class of its employees formerly covered under the Plan; or

(ii) starts to contribute to another multiemployer plan that is a group health plan with respect to a class of its employees formerly covered under the Plan.

For purposes of this rule:

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

- the last employer to contribute on behalf of a dependent is the last employer to have employed, and to have been obligated to make contributions on behalf of, the employee whose participation in the Plan permitted the dependent to be covered; or

(e) If coverage has been extended for up to 29 months due to disability and there is a final determination that the individual is no longer disabled.

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

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

Retiree Benefit Program

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

Compliance With Claim Rules

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

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

Amendment or Termination of the Plan

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

INFORMATION ABOUT THE PLAN

Plan Year and Benefit Period

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

Claim for Benefits

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

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

   Medical Claims
   Aetna
   P.O. Box 14079
   Lexington, KY 40512-4079

   Prescription Drug Claims
   Aetna Pharmacy Management
   P.O. Box 52444
   Phoenix, AZ 85072-2444

   Aetna
   P.O. Box 981106
   El Paso, TX 79998-1106

   Any benefit payment for services you receive from a non-contracting provider may, at Aetna's option, be paid directly to you. To the extent allowed by law, Aetna will not accept an assignment to a non-contracting provider.

2. Submitting a Claim for Benefits Provided Directly from the Trust Fund. The Trust Fund provides several benefits directly, rather than through an insurance company or Aetna. These benefits include Vision, Weekly Disability, Death, and Accidental Death and Dismemberment benefits. Claims for any of these benefits should be submitted to the Third-Party Administrator on forms available from the Third-Party Administrator's office. **All such claims must be filed within one year and 90 days after services are rendered.**

3. Submitting a Claim for Dental Benefits. The Dental Benefits are administered by Delta Dental. Any claims filed for dental benefits should be addressed to:

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

Coordination of Benefits

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

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

   (a) **Plan** means any of the following that provides benefits or services for medical or dental care or treatment. However, if separate benefit descriptions are used to provide coordinated coverage for subscribers of a group, the separate benefit descriptions are considered parts of the same Plan and there is no coordination of benefits among those separate benefit descriptions.

   - "Plan" includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans, or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   - "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

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

   (b) **Closed Panel Plan** means a Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

   (c) **Primary Plan** means a Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

   (d) **Secondary Plan** means a Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

   (e) **Allowable Expense** means a necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full

or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

(f) **Claim Determination Period** means a calendar year, but does not include any part of a year during which you are not covered under the Plan or any date before this Section or any similar provision takes effect.

(g) **Reasonable Cash Value** means an amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

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

2. Order of Benefit Determination Rules. A Plan that does not have a coordination of benefits rule consistent with this Section shall always be the Primary Plan. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement

a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

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

(a) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Plan is primary.

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

(i) The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

- The parents are married;
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

(ii) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.

(iii) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The Plan of the Custodial Parent;

- The Plan of the spouse of the Custodial Parent;
- The Plan of the noncustodial parent; and then
- The Plan of the spouse of the noncustodial parent.

(c) Active or Inactive Employee. The Plan that covers a person as an employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under subparagraph 2(a), above.

(d) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(e) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

(f) If the preceding rules do not determine the Primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this Section. In addition, the Plan will not pay more than it would have paid had it been primary.

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

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

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

4. Recovery of Excess Benefits. If the Plan pays charges for benefits that should have been paid by the Primary Plan, or if the Plan pays charges in excess of those for which it is

obligated to provide under the Plan, the Plan will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

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

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

One-Year Limitation on Legal Action

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

Coordination, Reimbursement, Subrogation and Set-Off

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

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

- Coordinate the benefits payable under the Plan with benefits payable under any other plan or by any other person, so that the total amount paid will not exceed your medical expenses;

- Seek reimbursement of excess payments from you, your parent or spouse if you are a dependent, any other plan or person which has received payment, or any other plan or person which should have made payment;

- Proceed to collect any claim you may have against any other plan or person for the injury or illness which occasioned the payment of benefits under the Plan; and

- Set off all or part of the amount it has not recovered against any amounts otherwise payable to you or on your behalf or to any person in your family or on his or her behalf.

Example:
Mark Young is an employee and is injured in an automobile accident. The Plan will take into account benefits payable under his automobile insurance policy as well as any benefits payable under the automobile insurance policy of anyone who may be liable for his injuries. And if the Plan chooses, it may bring suit directly against anyone who may be liable for his injuries. If the Plan pays his medical expenses and then he becomes entitled to receive compensation for his injuries from an insurance company, the Plan will demand that the insurance company first pay the Plan up to the amount of benefits the Plan paid for treatment of those injuries. If the insurance company does not reimburse the Plan, and Mark then receives compensation for his injuries from the insurance company, he must reimburse the Plan for the benefits the Plan paid for treatment of those injuries.

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

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

Name of Plan
Plumbing and Pipefitting Industry Health and Welfare Plan of Kansas

Name and Address of Sponsor
Board of Trustees of the
Plumbing and Pipefitting Industry
Health and Welfare Fund of Kansas
529 S Anna Street, Suite B
Wichita, Kansas 67209
316-264-2339
ONLINE www.bmgiweb.com/441

Sponsor IRS Identification and Plan Number
EIN: 48-6127146
PN: 501

Type of Plan
Health, Prescription Drug, Dental, Vision, Death, and Disability

Type of Plan Administration
The Plan is administered by the Board of Trustees.

Plumbing and Pipefitting Industry
Health and Welfare Fund of Kansas
529 S Anna Street, Suite B
Wichita, Kansas 67209
316-264-2339

Third-Party Administrator
Benefits Management Group, Inc.
529 S Anna Street, Suite B
Wichita, Kansas 67209
316-264-2339

Legal Process
Service of legal process can be served on the Plan Administrator at its address shown above, or on any of the Trustees at the address for the Joint Board of Trustees shown above.

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

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

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

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

TRUSTEES OF THE PLAN

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

Employer Trustees	**Employee Trustees**
Mr. Neil Carlson Plumbing By Carlson, Inc. 1820 SW Van Buren Topeka, KS 66612	Mr. Brian Burnett Business Manager Plumbers & Pipefitters Local Union 441 529 S Anna Street Wichita, KS 67209
Mr. Dan Beal McElroy's Inc. 3310 SW Topeka Boulevard Topeka, KS 66611	Mr. Matthew Wingert Business Representative Plumbers & Pipefitters Local Union 441 1793 E. 1068 Road Lawrence, KS 66049
Mr. Ronald D. Sturgeon President Sturgeon Plumbing & Air Conditioning Inc. P.O. Box 1769 Hutchinson, KS 67504-1769	Mr. Michael Thomas Business Representative Plumbers & Pipefitters Local Union 441 529 S Anna Street Wichita, KS 67209
Mr. Gregory S. Johnson Vice President Mechanical Systems Inc. P.O. Box 3029 Wichita, KS 67201-3029	Mr. Steve Watson Agent/Dispatcher Plumbers & Pipefitters Local Union 441 529 S Anna Street Wichita, KS 67209
Mike Wolownik 801 E Loren St. Frontenac, KS 66763	Levi Garrett c/o Local Union No. 441 103 Mendicki Drive Frontenac, KS 66763

YOUR RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

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

PART II

AETNA HEALTH CARE BENEFITS

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

When we use the words "you" and "your" in this Part II, we mean you and any covered dependents. The words "us," "we," and "our," where they appear in this Part II, mean Aetna. Words that are capitalized in this Part II are defined in the Glossary section of this Part II.

SPECIAL COVID-19 PROVISIONS

Notwithstanding any other provision of the Plan to the contrary:

- Effective for claims incurred on or after March 16, 2020, the Plan will waive the normal Coinsurance and share pay rules for COVID-19 testing expenses and the related consultative visit.

- The Plan will waive the normal Coinsurance and share pay rules for any item, service, or vaccine that becomes available and is intended to prevent or mitigate COVID-19 as required under Section 3203 of the Coronavirus Aid, Relief, and Economic Security Act of 2020. Such costs will be covered within 15 business days after the date on which the U.S. Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention recommends such item, service, or vaccine.

NOTICE OF GRANDFATHERED PLAN STATUS

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

AETNA SCHEDULE OF BENEFITS

This Schedule of Benefits lists the Coinsurance, if any, that applies to the Covered Services you receive under the Plan. You should review this Schedule of Benefits to become aware of the Coinsurance, as well as any limits that apply to these services.

HOW YOUR COST SHARE WORKS

- Coinsurance amounts, if any, listed in the Schedule of Benefits are what you will pay for Covered Services.
- You are responsible to pay any Coinsurance, if it applies, before the Plan will pay for any Covered Services.
- The Plan doesn't cover every health care service. You pay the full amount of any health care service you get that is not a Covered Service.
- The Plan has limits for some Covered Services. For example, these could be visit, day, or dollar limits. See the Schedule of Benefits for more information about limits.
- Your cost share may vary if the Covered Service is preventive or not.

  Important note: Covered Services are subject to the Maximum Out-of-Pocket Limits or Coinsurance unless otherwise stated in this Schedule of Benefits.

How your Physician office visit cost share works
You will pay the physician office visit cost share when you get Covered Services from any Physician.

How your maximum out-of-pocket works
This Schedule of Benefits shows the Maximum Out-of-Pocket Limits that apply to your Plan. Once you reach your Maximum Out-of-Pocket Limit, your Plan will pay for Covered Services for the remainder of that calendar year.

General coverage provisions
This section explains the Maximum Out-of-Pocket Limit and limitations listed in this Schedule of Benefits.

Coinsurance
This is the percentage of the bill you pay.

MAXIMUM OUT-OF-POCKET LIMIT PROVISIONS

Maximum Out-of-Pocket Limit
The Maximum Out-of-Pocket Limit is the most you will pay per year in Coinsurance, if any, for Covered Services. Covered Services that are subject to the Maximum Out-of-Pocket Limit include those provided under the medical benefit and the outpatient Prescription drug benefit.

Covered Services apply to the in-network and out-of-network Maximum Out-of-Pocket Limit.

Individual Maximum Out-of-Pocket Limit
The Plan has an individual and family Maximum Out-of-Pocket Limit. As to the individual Maximum Out-of-Pocket Limit, each of you must meet your Maximum Out-of-Pocket Limit separately.

After you or your covered dependents meet the individual Maximum Out-of-Pocket Limit, the Plan will pay 100% of the eligible charge for Covered Services that would apply toward the limit for the rest of the calendar year for that person.

Family Maximum Out-of-Pocket Limit
After you or your covered dependents meet the family Maximum Out-of-Pocket Limit, the Plan will pay 100% of the eligible charge for Covered Services that would apply toward the limit for the remainder of the calendar year for all covered family members. The family Maximum Out-of-Pocket Limit is a cumulative Maximum Out-of-Pocket Limit for all family members.

To satisfy this Maximum Out-of-Pocket Limit for the rest of the calendar year, the following must happen:

- The family Maximum Out-of-Pocket Limit is met by a combination of family members
- No one person within a family will contribute more than the individual Maximum Out-of-Pocket Limit amount in a calendar year.

If the Maximum Out-of-Pocket Limit does not apply to a Covered Service, your cost share for that service will not count toward satisfying the Maximum Out-of-Pocket Limit amount.

Certain costs that you have do not apply toward the Maximum Out-of-Pocket Limit. These include:

- All costs for non-Covered Services which are identified in the Plan and the Schedule of Benefits
- Charges, expenses or costs in excess of the allowable amount.

Limit provisions
Covered Services will apply to the in-network and out-of-network limits.

YOUR FINANCIAL RESPONSIBILITY AND DECISIONS REGARDING BENEFITS

We base your financial responsibility for the cost of Covered Services on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of Stays that occur in more than one year. Decisions regarding when benefits are covered are subject to the terms and conditions of the Plan.

OUTPATIENT PRESCRIPTION DRUG MAXIMUM OUT-OF-POCKET LIMITS PROVISIONS

Covered Services that are subject to the Maximum Out-of-Pocket Limit include Covered Services provided under the medical benefit and the Prescription drug benefit.

The Maximum Out-of-Pocket Limit is the most you will pay per year in Coinsurance, if any, for Covered Services. The Plan has an individual and family Maximum Out-of-Pocket Limit.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
Out-of-Pocket Maximum		
Individual	$2,000 per person	$2,500 per person
Family Maximum	$4,000 per family	$5,000 per family
BENEFIT HIGHLIGHTS	IN-NETWORK (Plan Pays)	OUT-OF-NETWORK (Plan Pays)
Acupuncture		
Acupuncture in lieu of anesthesia for a surgical or dental procedure is covered under the Plan if the Provider is a legally qualified Physician practicing within the scope of his/her license	50%	30%
Ambulance services		
Emergency Services Non-Emergency Services	50% per trip 50% per trip	50% per trip 30% per trip
Behavioral health (Coverage provided is the same as for any other illness)		
Mental health treatment		
Inpatient services-Room and Board including Residential Treatment Facility	50% per admission	30% per admission
Outpatient office visit to a Physician or Behavioral Health Provider Includes Telemedicine consultation	50% per visit	30% per visit
Outpatient mental health Telemedicine cognitive therapy consultations by a Physician or Behavioral Health Provider	50% per visit	30% per visit
Other outpatient services including: • Behavioral health services in the home • Partial Hospitalization treatment • Intensive outpatient program	50% per visit	30% per visit
Substance Related Disorders treatment (Includes Detoxification, rehabilitation and Residential Treatment Facility)		
Inpatient services (Room and Board during a Hospital Stay)	50% per admission	30% per admission
Outpatient office visit to a Physician or Behavioral Health Provider (includes Telemedicine consultation)	50% per visit	30% per visit
Outpatient Telemedicine cognitive therapy consultations by a Physician or Behavioral Health Provider	50% per visit	30% per visit
Other outpatient services including: • Behavioral health services in the home • Partial Hospitalization treatment • Intensive outpatient program	50% per visit	30% per visit

BENEFIT HIGHLIGHTS	IN-NETWORK (Plan Pays)	OUT-OF-NETWORK (Plan Pays)
Clinical trials		
Experimental or Investigational therapies	50% per visit	30% per visit
Routine patient cost	50% per visit	30% per visit
Durable medical equipment	50% per item	30% per item
Emergency Services		
Emergency room	50% per visit	50% per visit
Non-emergency care in a Hospital emergency room	50% per visit	30% per visit
Emergency Services important note: Out-of-Network Providers do not have a contract with us. The Provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the Provider and the amount paid by the Plan. However, for out-of-network emergencies the federal No Surprises Act applies. If the Provider bills you for an amount above your cost share, you are not responsible for payment of that amount.		
Habilitation therapy services (Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living)		
Physical and occupational therapies	50% (Covered based on type of service and where it is received)	30% (Covered based on type of service and where it is received)
Speech therapy	50% (Covered based on type of service and where it is received)	30% (Covered based on type of service and where it is received)
Home health care	50% per visit	30% per visit
A visit by a Home Health Aide of 4 hours or less = 1 visit; a visit by a Nurse or Therapist = 1 visit Home health care important note: Intermittent visits are periodic and recurring visits that skilled nurses make to ensure your proper care. The intermittent requirement may be waived to allow for coverage for up to 12 hours with a daily maximum of 3 visits		
Hospice care		
Inpatient services - Room and Board	50% per admission	30% per admission
Outpatient services	50% per visit	30% per visit
Limit per lifetime	Unlimited	Unlimited
Hospice important note: This includes part-time or infrequent nursing care by an R.N. or L.P.N. to care for you up to 8 hours a day. It also includes part-time or infrequent home health aide services to care for you up to 8 hours a day.		
Hospital care Inpatient services – Room and Board	50% per admission	30% per admission
Infertility services		
Treatment of basic Infertility, limited to coverage for the treatment for an underlying medical condition up to the point an Infertility condition is diagnosed	50% (Covered based on type of service and where it is received)	30% (Covered based on type of service and where it is received)
Jaw Joint Disorder (Includes TMJ)	50% (Covered based on type of service and where it is received)	30% (Covered based on type of service and where it is received)

BENEFIT HIGHLIGHTS	IN-NETWORK (Plan Pays)	OUT-OF-NETWORK (Plan Pays)
Maternity and related newborn care (Includes complications)		
Inpatient services – Room and Board	50% per admission	30% per admission
Services performed in Physician or Specialist office or a facility	50% per visit	30% per visit
Other services and supplies	50%	30%
Maternity and related newborn care important note: Any cost share collected applies only to the delivery and postpartum care services provided by an OB, GYN or OB/GYN. Review the Maternity section of the Plan.		
Nutritional Evaluation		
Nutritional evaluation and counseling for treatment of chronic disease (including eating disorders) (limited to 3 visits per calendar year)	50%	30%
Oral and maxillofacial treatment (mouth, jaws and teeth)		
Treatment of mouth, jaws and teeth, limited to charges made for oral Surgery or for a continuous course of dental treatment started within 6 months of an injury to sound natural teeth	50%	30%
Outpatient Prescription drugs		
Generic 30-day supply at a Retail Pharmacy	50%	50%
Generic 90-day supply at a Mail Order Pharmacy	50%	Not covered
Brand-name 30-day supply at a Retail Pharmacy	50%	50%
Brand-name 90-day supply at a Mail Order Pharmacy	50%	Not covered
Oral anti-cancer drugs 30-day supply at a Retail Pharmacy	50%	50%
Oral anti-cancer drugs 30-day supply at a Retail Pharmacy	50%	50%
Outpatient Prescription drug important note: If a Provider prescribes a covered Brand-Name Prescription Drug when a Generic Prescription Drug equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost share for the Brand-Name Prescription Drug. If a Provider does not specify DAW and you request a covered Brand-Name Prescription Drug, you will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug, plus the cost share that applies to the Brand-Name Prescription Drug.		
Outpatient Surgery		
At Hospital outpatient department	50% per visit	30% per visit
Physician and Specialist services		
Physician services - general or family practitioner		
Physician office hours (not-surgical, not preventive)	50% per visit	30% per visit
Physician surgical services	50% per visit	30% per visit
Physician Telemedicine consultation	50% per visit	30% per visit
Physician visit during inpatient Stay	50% per visit	30% per visit

BENEFIT HIGHLIGHTS	IN-NETWORK (Plan Pays)	OUT-OF-NETWORK (Plan Pays)
Specialist		
Specialist office hours (not-surgical, not preventive)	50% per visit	30% per visit
Specialist surgical services	50% per visit	30% per visit
Specialist Telemedicine consultation	50% per visit	30% per visit
All other services not shown above		
All other services	50% per visit	30% per visit
Preventive care		
Breast feeding counseling and support	50% per visit	30% per visit
Breast feeding counseling and support limit	6 visits in a 12-month period; visits that exceed the limit are covered under the Physician services office visit	6 visits in 12-month period; visits that exceed the limit are covered under the Physician services office visit
Breast pump, accessories and supplies limit	1 breast pump (including accessories and supplies) per 12-month period	1 breast pump (including accessories and supplies) per 12-month period
Family planning services (female contraception counseling)	50% per visit	30% per visit
Immunizations	50% (Flu shots and Covid shots covered at 100%)	30% (Flu shots and Covid shots covered at 100%)
Routine physical exam	50% per visit	30% per visit
Well woman GYN exam	50% per visit	30% per visit
Prosthetic devices	50% (Covered based on type of service and where it is received)	30% (Covered based on type of service and where it is received)
Reconstructive Surgery and supplies (including breast Surgery)	50% (Covered based on type of service and where it is received)	30% (Covered based on type of service and where it is received)
Routine cancer screening		
Colonoscopy	50% per visit	30% per visit
Digital rectal examination (DRE)	50% per visit	30% per visit
Double contrast barium enemas (DCBE)	50% per visit	30% per visit
Fecal occult blood test (FOBT)	50% per visit	30% per visit
Mammogram	50% per visit	30% per visit
Prostate specific antigen (PSA) test	50% per visit	30% per visit
Sigmoidoscopy	50% per visit	30% per visit
Lung cancer screening	50% per visit	30% per visit
Short-term rehabilitation services		
Cardiac rehabilitation		
Pulmonary		
Cognitive rehabilitation		

BENEFIT HIGHLIGHTS	IN-NETWORK (Plan Pays)	OUT-OF-NETWORK (Plan Pays)
Outpatient physical, occupational and speech therapies (For treatment of acute conditions of such services will result in significant improvement in your condition within a 60-day period)		
Physical and occupational therapy	50% per visit	30% per visit
Speech therapy (limited to 90 visits per calendar year)	50% per visit	30% per visit
Spinal manipulation (subject to a maximum of $800 per year per family)	50% per visit	30% per visit
Skilled Nursing Facility		
Inpatient services - Room and Board	50% per admission	30% per admission
Other inpatient services and supplies	50% per admission	30% per admission
Tests, images and labs – outpatient		
Diagnostic complex imaging services	50% per visit	30% per visit
Diagnostic lab work	50% per visit	30% per visit
Diagnostic x-ray and other radiological services	50% per visit	30% per visit
Therapies		
Chemotherapy services	50% (Covered based on type of service and where it is received)	30% (Covered based on type of service and where it is received)
Outpatient infusion therapy services (chemotherapy, hydration therapy, etc.)	50% per visit	30% per visit
Radiation therapy	50% (Covered based on type of service and where it is received)	30% (Covered based on type of service and where it is received)
Respiratory therapy	50% (Covered based on type of service and where it is received)	30% (Covered based on type of service and where it is received)
Transplant services		
Inpatient services and supplies	50% per transplant	30% per transplant
Physician services	50% (Covered based on type of service and where it is received)	30% (Covered based on type of service and where it is received)
Lodging and travel maximum	$50 per night per person ($100 per night total); overall travel and lodging $10,000 combined lodging/travel per procedure treatment or type	No coverage
Urgent care services at a freestanding facility or Provider that is not a Hospital (A separate urgent care cost share will apply for each visit to an urgent care facility or Provider)		
Urgent care facility	50% per visit	50% per visit
Non-urgent use of an urgent care facility or Provider	50% per visit	30% per visit

BENEFIT HIGHLIGHTS	IN-NETWORK (Plan Pays)	OUT-OF-NETWORK (Plan Pays)
Walk-In Clinic		
Non-Emergency Services	50% per visit	30% per visit
Preventive Immunizations (subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention	50% per visit (flu shots and Covid shots covered at 100%)	30% per visit (flu shots and Covid shots covered at 100%)

Coverage and Exclusions.

1. Providing Covered Services. Your Plan provides Covered Services. These are:

- Described in this section.
- Not listed as an exclusion in this section or the *General Plan Exclusions* section of this Part II.
- Not beyond any limits in the *Schedule of Benefits* found in this Part II.
- Medically Necessary. See the *Medical Necessity and precertification requirements* and the *Glossary* sections of this Part II for more information.

For Covered Services under the outpatient Prescription drug benefit:

- You need a Prescription from the prescribing Provider
- You need to show your ID card to the network pharmacy when you get a Prescription filled

The Plan provides coverage for many kinds of Covered Services, such as a doctor's care and Hospital Stays, but some services aren't covered at all or are limited. For other services, the Plan pays more of the expense. For example:

- Physician care generally is covered but Physician care for cosmetic Surgery is never covered. This is an exclusion.
- Home health care is generally covered but it is a Covered Service only up to a set number of visits a year. This is a limitation.
- Your Provider may recommend services that are considered Experimental or Investigational services. But an Experimental or Investigational service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a Terminal Illness. See *Clinical trials* in the list of services below.

Some services require precertification from us. For more information see the *Medical Necessity and precertification requirements* section of this Part II.

The Covered Services and exclusions below appear alphabetically to make it easier to find what you're looking for. You can find out about limitations for Covered Services in the *Schedule of Benefits* found in this Part II. If you have questions, contact us at 1-888-290-7241.

2. Acupuncture. Covered Services include acupuncture services provided by a Physician if the service is provided as a form of anesthesia in connection with a covered Surgical Procedure.

   The following are not Covered Services:

   - Acupuncture, other than for anesthesia
   - Acupressure

3. Ambulance services. An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

   (a) Emergency Ground Ambulance. Covered Services include emergency transport to a Hospital by a licensed ambulance:

   - To the first Hospital to provide Emergency Services
   - From one Hospital to another if the first Hospital can't provide the Emergency Services you need
   - When your condition is unstable and requires medical supervision and rapid transport

   (b) Non-emergency Ground Ambulance. Covered Services also include transportation to a Hospital by a licensed ambulance:

   - From a Hospital to your home or to another facility if an ambulance is the only safe way to transport you
   - From your home to a Hospital if an ambulance is the only safe way to transport you; limited to 100 miles
   - When during a covered inpatient Stay at a Hospital, Skilled Nursing Facility or acute rehabilitation Hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

   The following are not Covered Services:

   - Ambulance services for routine transportation to receive outpatient or inpatient services

4. Behavioral health.

(a) Mental health treatment. Covered Services include the treatment of Mental Health Disorders provided by a Hospital, Psychiatric Hospital, Residential Treatment Facility, Physician, or Behavioral Health Provider including:

- Inpatient Room and Board at the Semi-Private Room Rate (your Plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your Stay in a Hospital, Psychiatric Hospital, or Residential Treatment Facility
- Outpatient treatment received while not confined as an inpatient in a Hospital, Psychiatric Hospital, or Residential Treatment Facility, including:
  - Office visits to a Physician or Behavioral Health Provider such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes Telemedicine consultation)
  - Individual, group, and family therapies for the treatment of Mental Health Disorders
  - Other outpatient mental health treatment such as:
    - Partial Hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a Physician
    - Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a Physician
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your Physician orders them
      - The services take the place of a Stay in a Hospital or a Residential Treatment Facility, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Electro-convulsive therapy (ECT)

- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Peer counseling support by a peer support Specialist

A peer support Specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a Behavioral Health Provider.

(b) Substance Related Disorders treatment. Covered Services include the treatment of Substance Related Disorders provided by a Hospital, Psychiatric Hospital, Residential Treatment Facility, Physician, or Behavioral Health Provider as follows:

- Inpatient Room and Board, at the Semi-Private Room Rate (your Plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your Stay in a Hospital, Psychiatric Hospital, or Residential Treatment Facility
- Outpatient treatment received while not confined as an inpatient in a Hospital, Psychiatric Hospital
- Residential Treatment Facility, including:
  - Office visits to a Physician or Behavioral Health Provider such as a psychologist, social worker, or licensed professional counselor (includes Telemedicine consultation)
  - Individual, group, and family therapies for the treatment of Substance Related Disorders
  - Other outpatient Substance Related Disorders treatment such as:
    - Partial Hospitalization treatment provided in a facility or program for treatment of Substance Related Disorders provided under the direction of a Physician
    - Intensive outpatient program provided in a facility or program for treatment of Substance Related Disorders provided under the direction of a Physician

- Ambulatory or outpatient Detoxification which include outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
- Observation
- Peer counseling support by a peer support Specialist

A peer support Specialist serves as a role model, mentor, coach, and advocate. They must be certified by the state where the services are provided or a private certifying organization recognized by us. Peer support must be supervised by a Behavioral Health Provider.

5. Clinical trials.

(a) Routine patient costs. Covered Services include routine patient costs you have from a Provider in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not Covered Services:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising Experimental or Investigational interventions for Terminal Illnesses in certain clinical trials in accordance with our policies)

(b) Experimental or Investigational therapies. Covered Services include drugs, devices, treatments, or procedures from a Provider under an "approved clinical trial" only when you have cancer or a Terminal Illness. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it

- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
    - It conforms to standards of the NCI or other applicable federal organization
    - It takes place at an NCI-designated cancer center or at more than one institution
    - You are treated in accordance with the procedures of that study

6. Durable medical equipment (DME). DME and the accessories needed to operate it are:

- Made to withstand prolonged use
- Mainly used in the treatment of illness or injury
- Suited for use in the home
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Your Plan only covers the same type of DME that Medicare covers but, there are some DME items Medicare covers that your Plan does not.

Covered Services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

Covered Services also include:

- One item of DME for the same or similar purpose
- Repairing DME due to normal wear and tear
- A new DME item you need because your physical condition has changed
- Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not Covered Services:

- Communication aid
- Elevator

- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

7. Emergency Services. When you experience an Emergency Medical Condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

   Covered Services include only outpatient services to evaluate and stabilize an Emergency Medical Condition in a Hospital emergency room. You can get Emergency Services from Network Providers or Out-of-Network Providers.

   If your Physician decides you need to Stay in the Hospital (emergency admission) or receive follow-up care, these are not Emergency Services. Different benefits and requirements apply. Please refer to the *Medical Necessity and precertification requirements* section and the *Coverage and Exclusions* section of this Part II that fits your situation (for example, Hospital care or Physician services). You can also contact us at 1-888-290-7241, or contact your network Physician or Primary Care Physician (PCP).

   If you go to an emergency room for what is not an Emergency Medical Condition, the Plan may not cover your expenses. See the *Schedule of Benefits* in this Part II for this information.

8. Genetic Testing. Covered Services include charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

   - A person has symptoms or signs of a genetically-linked inheritable disease;
   - It has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

- The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

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

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

9. Habilitation therapy services. Habilitation therapy services help you keep, learn or improve skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your Physician. The services must be performed by a:

- Licensed or certified physical, occupational or speech therapist
- Hospital, Skilled Nursing Facility or hospice facility
- Home Health Care Agency
- Physician

Covered Services include:

- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development (speech function is the ability to express thoughts, speak words and form sentences)

The following are not Covered Services:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

10. Home health care. Covered Services include home health care provided by a Home Health Care Agency in the home, but only when all of the following criteria are met:

- You are homebound
- Your Physician orders them

- The services take the place of a Stay in a Hospital or a Skilled Nursing Facility, or you are unable to receive the same services outside your home
- The services are a part of a home health care plan
- The services are Skilled Nursing Services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a Physician or social worker

If you are discharged from a Hospital or Skilled Nursing Facility after a Stay, the intermittent requirement may be waived to allow coverage for continuous Skilled Nursing Services. See the *Schedule of Benefits* in this Part II for more information on the intermittent requirement.

Short-term physical, speech, and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See the *Schedule of Benefits* in this Part II.

The following are not Covered Services:

- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present

11. Hospice care. Covered Services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

- Room and Board
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a Hospital
- Psychological and dietary counseling
- Pain management and symptom control

- Bereavement counseling
- Respite care

Hospice care services provided by the Providers below will be covered, even if the Providers are not an employee of the hospice care agency responsible for your care:

- A Physician for consultation or case management
- A physical or occupational therapist
- A Home Health Care Agency for:
    - Physical and occupational therapy
    - Medical supplies
    - Outpatient Prescription drugs
    - Psychological counseling
    - Dietary counseling

The following are not Covered Services:

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling including estate planning and the drafting of a will
- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
    - Sitter or companion services for you or other family members
    - Transportation
    - Maintenance of the house

12. Hospital care. Covered Services include inpatient and outpatient Hospital care. This includes:

- Semi-private Room and Board
- Services and supplies provided by the outpatient department of a Hospital, including the facility charge

- Services of Physicians employed by the Hospital
- Administration of blood and blood derivatives, but not the expense of the blood or blood product

The following are not Covered Services:

- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

13. Infertility services - Basic Infertility. Covered Services include seeing a Provider:

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

The following are not Covered Services:

- All Infertility services associated with or in support of an ovulation induction cycle while on injectable medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services
- Artificial insemination services

14. Institutes of Quality. Aetna Institutes of Quality (IOQ) program is a network of facilities/clinics of publicly recognized, high-quality, high-value health care Providers. These Providers offer access to a quality and efficient network for specific procedures. The Institutes have met extensive quality, as well as cost-effectiveness criteria. The Institutes of Quality program applies to adult members (age 18 and over) only.

The IOQs are Aetna facilities participating under standard Aetna contracts and are designated through a targeted Request For Information (RFI) process. Designation is valid for two years provided that the facility maintains compliance with the IOQ program requirements.

15. Institutes of Quality Cardiac Care. Institutes of Quality Cardiac Care facilities is a network of Providers that have met Aetna's requirements for clinical quality, value and access for cardiac care. Aetna worked with heart experts and professional groups to create our quality network requirements. These groups include the American College of Cardiology (ACC) and the Society for Thoracic Surgeons (STS).

    Cardiac IOQ facilities provide the following services:

    - Rhythm
        - Pacemakers - small battery-powered device that sends weak electrical impulses to enable heart to keep a regular heartbeat
        - Defibrillator - small battery-powered device used to treat an abnormal heart rhythm or rate
    - Interventional
        - Heart Cath - procedure performed to show blood flow through heart chambers and arteries
        - PTCA - balloon opening artery of heart
        - Stent - small expandable tube used to keep an artery open to increase blood flow
    - Surgery
        - CABG, Valve w/ CABG, Valve w/out CABG - repairing or replacing the damaged flaps inside the heart to allow blood to flow more easily and in the right direction

16. Jaw Joint Disorder treatment. Covered Services include the diagnosis and surgical treatment of Jaw Joint Disorder by a Provider, including:

    - The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
    - The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

    The following are not Covered Services:

    - Non-surgical medical and dental services, and therapeutic services related to Jaw Joint Disorder

17. Maternity and related newborn care. Covered Services include pregnancy (prenatal) care, care after delivery and obstetrical services. After your child is born, Covered Services include:

    - No less than 48 hours of inpatient care in a Hospital after a vaginal delivery
    - No less than 96 hours of inpatient care in a Hospital after a cesarean delivery
    - A shorter Stay, if the attending Physician, with the consent of the mother, discharges the mother or newborn earlier

    Covered Services also include services and supplies needed for circumcision by a Provider. The following are not Covered Services:

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

18. Nutritional Evaluation. Subject to the limitations set forth in the *Schedule of Benefits* in this Part II, Covered Services include charges made for nutritional evaluation and counseling when diet is a part of the medical management of a chronic disease (including eating disorders).

19. Oral and maxillofacial treatment (mouth, jaws and teeth). Covered Services include the following when provided by a Physician, dentist and Hospital:

    - Cutting out:
        - Cysts, tumors, or other diseased tissues
    - Cutting into gums and tissues of the mouth.
        - Only when not associated with the removal, replacement or repair of teeth

20. Outpatient Surgery. Covered Services include services provided and supplies used in connection with outpatient Surgery performed in a Surgery center or a Hospital's outpatient department.

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

    The following are not Covered Services:

    - A Stay in a Hospital (see *Hospital care* in this section)
    - A separate facility charge for Surgery performed in a Physician's office
    - Services of another Physician for the administration of a local anesthetic

21. Physician services. Covered Services include services by your Physician to treat an illness or injury. You can get services:

- At the Physician's office
- In your home
- In a Hospital
- From any other inpatient or outpatient facility
- By way of Telemedicine

Important note: For behavioral health services, all in-person, Covered Services with a Behavioral Health Provider are also Covered Services if you use Telemedicine instead.

Other services and supplies that your Physician may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations (other than flu shots and COVID vaccines that are covered as preventive care)

22. Prescription drugs - outpatient. Read this section carefully. The Plan does not cover all Prescription drugs and some coverage may be limited. This doesn't mean you can't get Prescription drugs that aren't covered; you can, but you have to pay for them yourself. For more information about Prescription drug benefits, including limits, see the *Schedule of Benefits* in this Part II.

Important note: A pharmacy may refuse to fill or refill a Prescription when, in the professional judgement of the pharmacist, it should not be filled or refilled.

Your Plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's FDA-approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

Covered Services are based on the drugs in the Drug Guide. We exclude Prescription drugs listed on the Formulary Exclusions List unless we approve a medical exception. If it is Medically Necessary for you to use a Prescription drug that is not on this Drug Guide, you or your Provider must request a medical exception.

Your Provider can give you a Prescription in different ways including:

- A written Prescription that you take to a network pharmacy

- Calling or e-mailing a Prescription to a network pharmacy
- Submitting the Prescription to a network pharmacy electronically

(a) How to access network pharmacies. You can find a network pharmacy either online through your member website at http://www.aetna.com or by phone at (888) 290-7241.

You may go to any network pharmacies. Pharmacies include network Retail, Mail Order and Specialty Pharmacies.

Some Prescription drugs are subject to quantity limits. This helps your Provider and pharmacy ensure your Prescription drug is being used correctly and safely. We rely on medical guidelines, FDA-approved recommendations and other criteria developed by us to set these limits.

Any Prescription drug made to work beyond one month shall require the Coinsurance amount that equals the expected duration of the medication.

The pharmacy may substitute a Generic Prescription Drug for a Brand-Name Prescription Drug. Your cost share may be less if you use a Generic Prescription Drug when it is available.

(b) Retail Pharmacy. A Retail Pharmacy may be used for up to a 90 day supply of Prescription drugs. A network Retail Pharmacy will submit your claim. You will pay your cost share directly to the pharmacy. There are no claim forms to complete or submit.

(c) Mail Order Pharmacy. The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Each Prescription and refill is limited to a maximum 90 day supply.

Prescription refills after the initial fill can be filled at a network Mail Order Pharmacy. For information on locating a network Mail Order Pharmacy, contact CVS Caremark at 1-800-227-5720.

(d) Specialty Pharmacy. We cover Specialty Prescription Drugs when filled through a network Retail or Specialty Pharmacy. Each Prescription is limited to a maximum 30 day supply.

All Specialty Prescription Drug fills including the initial fill must be filled at a network Specialty Pharmacy unless it is an urgent situation.

Prescription drugs covered by the Plan are subject to misuse, waste, or abuse utilization review by us, your Provider, and/or your network pharmacy. The outcome of this review may include:

- Limiting coverage of a drug to one prescribing Provider or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

(e) PrudentRx Solution for Specialty Medications. In order to provide a comprehensive and cost-effective prescription drug program for you and your family, the Plan has contracted to offer the PrudentRx Solution for certain specialty medications. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the Plan's specialty drug list are included in the program and will be subject to a 30% co-insurance. However, if a member enrolls in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications, thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you choose to opt out of the program, you must call 1-800-578-4403. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. Eligible members who choose to decline enrollment in an available manufacturer copay assistance program will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is Medically Necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

(f) How to access out-of-network pharmacies. You can directly access an out-of-network pharmacy to get covered outpatient Prescription drugs.

When you use an out-of-network pharmacy, you pay your in-network Coinsurance and then you pay your out-of-network Coinsurance. If you use an out-of-network pharmacy to obtain outpatient Prescription drugs, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your in-network outpatient Prescription drug cost share
- Your out-of-network Coinsurance
- Any charges over the allowable amount
- Submitting your own claims

(g) What if the pharmacy you use leaves the network. Sometimes a pharmacy might leave the network. If this happens, you will have to get your Prescriptions filled at another network pharmacy. You can use your Provider directory or call us at 1-888-290-7241 to find another network pharmacy in your area.

(h) How to get an emergency Prescription filled. You may not have access to a network pharmacy in an emergency or urgent situation or you may be traveling outside of your Plan's service area. If you must fill a Prescription in any of these situations, we will reimburse you as shown in the table below:

Type of pharmacy	Your cost share is
A network pharmacy	The Plan cost share
Out-of-network pharmacy	The full cost of the Prescription

When you pay the full cost of the Prescription at an out-of-network pharmacy:

- You will fill out and send a Prescription drug refund form to us, including all itemized pharmacy receipts

- Coverage will be limited to items obtained in connection with the out-of-area emergency or urgent situation
- Submission of the refund form doesn't guarantee a refund. If approved, you will be reimbursed the cost of the Prescription less your network cost share

(i) Other Covered Services.

(i) Anti-cancer drugs taken by mouth, including chemotherapy drugs. Covered Services include any drug prescribed for cancer treatment. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

(ii) Contraceptives (birth control). For females who are able to become pregnant, Covered Services include certain drugs and devices that the FDA has approved to prevent pregnancy. You will need a Prescription from your Provider and must fill it at a network pharmacy. At least one form of each FDA-approved contraception method is a Covered Service. You can access a list of covered drugs and devices.

(iii) Diabetic supplies. Covered Services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid
- Diabetic syringes, needles and pens
- Continuous glucose monitors
- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine
- Blood glucose meters and insulin pumps

(iv) Immunizations. Covered Services include preventive immunizations when given by a network pharmacy. You can find a participating network pharmacy by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

(v) Risk reducing breast cancer Prescription drugs. Covered Services include Prescription drugs used to treat people who are at:

- Increased risk for breast cancer
- Low risk for medication side effects

(j) Prescription Drug Exclusions. The following are not Covered Services:

- Abortion drugs
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded Prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a Covered Service
- Drugs or medications
  - Administered or entirely consumed at the time and place it is prescribed or provided
  - Which do not require a Prescription by law, even if a Prescription is written, unless we have approved a medical exception
  - That include the same active ingredient or a modified version of an active ingredient as a covered Prescription drug unless we approve a medical exception
  - That is therapeutically the same or an alternative to a covered Prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical benefit while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)

- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a Covered Service

- That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications

- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies

- Duplicative drug therapy; for example, two antihistamines for the same condition

- Genetic care including:

  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes

- Immunizations related to travel or work

- Immunization or immunological agents except as specifically stated in this Part II and the *Schedule of Benefits*

- Implantable drugs and associated devices except as specifically stated in this Part II and the *Schedule of Benefits*

- Infertility:

  - Prescription drugs used primarily for the treatment of Infertility

- Injectables including:

  - Any charges for the administration or injection of Prescription drugs

  - Needles and syringes except for those used for insulin administration

  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified Provider or licensed certified Health Professional in an outpatient setting with

the exception of Depo Provera and other injectable drugs for contraception

- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the Plan's Drug Guide
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which is illegal, unethical, imprudent, abusive, not Medically Necessary or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen Prescriptions
- Test agents except diabetic test agents
- Treatment, drug, service or supply to stop or reduce smoking or the use of tobacco products or to treat or reduce nicotine addition, dependence or craving including medications, nicotine patches and gum unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the Plan's Drug Guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the Plan's Drug Guide

23. Prosthetic device. A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

    Covered Services include the initial provision and subsequent replacement of a prosthetic device that your Physician orders and administers.

    Coverage includes:

    - Instruction and other services (such as attachment or insertion) so you can properly use the device

- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed

- Replacements required by ordinary wear and tear or damage

You may receive a prosthetic device as part of another Covered Service and therefore it will not be covered under this benefit.

The following are not Covered Services:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace

- Trusses, corsets, and other support items

- Repair and replacement due to loss, misuse, abuse or theft

24. Reconstructive breast Surgery and supplies. Covered Services include all stages of reconstructive Surgery by your Provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

    - Your Surgery reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:

        - Surgery on a healthy breast to make it symmetrical with the reconstructed breast

        - Treatment of physical complications of all stages of the mastectomy, including lymphedema

        - Prostheses

25. Reconstructive Surgery and supplies. Covered Services include all stages of reconstructive Surgery by your Provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

    - Your Surgery is to implant or attach a covered prosthetic device.

    - Your Surgery corrects a gross anatomical defect present at birth. The Surgery will be covered if:

        - The defect results in severe facial disfigurement or major functional impairment of a body part

        - The purpose of the Surgery is to improve function

- Your Surgery is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your Surgery will improve function.

Covered Services also include the procedures or Surgery to sound natural teeth injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The Surgery or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

26. Short-term cardiac and pulmonary rehabilitation services.

(a) Cardiac rehabilitation. Covered Services include cardiac rehabilitation services you receive at a Hospital, Skilled Nursing Facility or Physician's office, but only if those services are part of a treatment plan determined by your risk level and ordered by your Physician.

(b) Pulmonary rehabilitation. Covered Services include pulmonary rehabilitation services as part of your inpatient Hospital Stay if they are part of a treatment plan ordered by your Physician. A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a Hospital, Skilled Nursing Facility, or Physician's office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your Physician.

27. Short-term rehabilitation services. Short-term rehabilitation services help you restore or develop skills and functioning for daily living. The services must follow a specific treatment plan, ordered by your Physician. The services have to be performed by a:

- Licensed or certified physical, occupational, or speech therapist
- Hospital, Skilled Nursing Facility, or hospice facility
- Home Health Care Agency
- Physician

Covered Services include:

- Spinal manipulation to correct a muscular or skeletal problem. Your Provider must establish or approve a treatment plan that details the treatment and specifies frequency and duration.

28. Cognitive rehabilitation, physical, occupational, and speech therapy. Covered Services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or Surgical Procedure
- Occupational therapy, but only if it is expected to do one of the following:
  - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or Surgical Procedure
  - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
  - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or Surgical Procedure
  - Improve delays in speech function development caused by a gross anatomical defect present at birth (Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.)
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the *Schedule of Benefits* located in this Part II.

The following are not Covered Services:

- Services provided in an educational or training setting or to teach sign language

- Vocational rehabilitation or employment counseling

29. Skilled Nursing Facility. Covered Services include precertified inpatient Skilled Nursing Facility care. This includes:

    - Room and Board, up to the Semi-Private Room Rate
    - Services and supplies provided during a Stay in a Skilled Nursing Facility

30. Tests, images and labs.

    (a) Diagnostic complex imaging services. Covered Services include:

    - Computed tomography (CT) scans, including for preoperative testing
    - Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
    - Nuclear medicine imaging including positron emission tomography (PET) scans
    - Other imaging service where the billed charge exceeds $500 Complex imaging for preoperative testing is covered under this benefit.

    (b) Diagnostic lab work. Covered Services include:

    - Lab
    - Pathology
    - Other tests

    These are covered only when you get them from a licensed radiology Provider or lab.

    (c) Diagnostic x-ray and other radiological services. Covered Services include x-rays, scans and other services (but not complex imaging) only when you get them from a licensed radiology Provider. See *Diagnostic complex imaging services* above for more information.

31. Therapies – chemotherapy, infusion, radiation.

    (a) Chemotherapy. Covered Services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your Hospital benefit covers the initial dose of chemotherapy after a cancer diagnosis during a Hospital Stay.

(b) Infusion therapy. Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions. Covered Services include infusion therapy you receive in an outpatient setting including but not limited to:

- A freestanding outpatient facility
- The outpatient department of a Hospital
- A Physician's office
- Your home from a home care Provider

You can access the list of preferred infusion locations by contacting us.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

Certain infused medications may be covered under the outpatient Prescription drug benefit. You can access the list of Specialty Prescription Drugs by contacting us.

(c) Radiation therapy. Covered Services include the following radiology services provided by a Health Professional:

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

32. Transplant services. Covered Services include transplant services provided by a Physician and Hospital.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow

- CAR-T and T Cell receptor therapy for FDA-approved treatments
- Thymus tissue for FDA-approved treatments]

Covered Services also include:

- Travel and lodging expenses
    - If you are working with an Institutes of Excellence™ (IOE) facility that is 100 or more miles away from where you live, travel and lodging expenses are Covered Services for you and a companion, to travel between home and the IOE facility
    - Coach class air fare, train or bus travel are examples of Covered Services

We designate facilities to provide specific services or procedures. They are listed as Institutes of Excellence™ (IOE) facilities in your Provider directory.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the facility we designate to perform the transplant you need.

Transplant services received from an IOE facility are subject to the network Coinsurance and maximum out-of-pocket and limits, unless stated differently in this Part II and the schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network Coinsurance and maximum out-of-pocket, and limits, unless stated differently in this Part II and the *Schedule of Benefits*.

Important note: If there are no IOE facilities assigned to perform your transplant type in your network, it's important that you contact us at 1-888-290-7241 so we can help you determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility we designate, your cost share will be higher.

Many pre and post transplant medical services, even routine ones, are related to and may affect the success of your transplant. If your transplant care is being coordinated by the National Medical Excellence® (NME) program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the Covered Service is not directly related to your transplant.

The following are not Covered Services:

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness

- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

33. Urgent care services. Covered Services include services and supplies to treat an Urgent Condition at an urgent care center. An "urgent care center" is a facility licensed as a freestanding medical facility to treat Urgent Conditions. Urgent Conditions need prompt medical attention but are not life-threatening.

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

    If you go to an urgent care center for what is not an Urgent Condition, the Plan may not cover your expenses. See the *Schedule of Benefits* in this Part II for more information.

    Covered Services include services and supplies to treat an Urgent Condition at an urgent care center as described below:

    - Urgent Condition within the network (in-network)
        - If you need care for an Urgent Condition, you should first seek care through your Physician, PCP. If your Physician is not reasonably available, you may access urgent care from an urgent care center that is in-network.
    - Urgent Condition outside the network (out-of-network)
        - You are covered for urgent care obtained from a facility that is out-of-network if you are temporarily unable to get services in-network and getting the health care service cannot be delayed.

34. Walk-In Clinic. Covered Services include, but are not limited to, health care services provided at a Walk-In Clinic for:

    - Scheduled and unscheduled visits for illnesses and injuries that are not Emergency Medical Conditions
    - Preventive care immunizations administered within the scope of the clinic's license

General Plan Exclusions.
The following are not Covered Services under your Plan:

1. Behavioral health treatment. Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association:

- Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
- School and/or education service, including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation
- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders and nicotine dependence except as described in the *Coverage and Exclusions* section of this Part II
- Pathological gambling, kleptomania, and pyromania
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

2. Blood, blood plasma, synthetic blood, blood derivatives or substitutes. Examples of these are:
   - The provision of blood to the Hospital, other than blood derived clotting factors
   - Any related services including processing, storage or replacement expenses
   - The service of blood donors, including yourself, apheresis or plasmapheresis
   - The blood you donate for your own use, excluding administration and processing expenses and except where described in the *Transplant services* section of this Part II.
3. Cosmetic services and plastic Surgery. Any treatment, Surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons, except where described in the *Reconstructive breast Surgery and supplies* and *Reconstructive Surgery and supplies* sections of this Part II.
4. Cost share waived. Any cost for a service when any Out-of-Network Provider waives all or part of your Coinsurance or any other amount.

5. Court-ordered services and supplies. This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a Covered Service under your Plan.

6. Custodial care. Services and supplies meant to help you with activities of daily living or other personal needs. Examples of these are:

   - Routine patient care such as changing dressings, periodic turning and positioning in bed
   - Administering oral medications
   - Care of stable tracheostomy (including intermittent suctioning)
   - Care of a stable colostomy/ileostomy
   - Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
   - Care of a bladder catheter, including emptying or changing containers and clamping tubing
   - Watching or protecting you
   - Respite care, adult or child day care, or convalescent care
   - Institutional care, including Room and Board for rest cures, adult day care and convalescent care
   - Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
   - Any other services that a person without medical or paramedical training could be trained to perform

7. Dental services. The following are not Covered Services:

   - Services normally covered under a dental plan
   - Dental implants

8. Educational services. Examples of these are:

   - Any service or supply for education, training or retraining services or testing. This includes:
     - Special education

- Remedial education
- Wilderness treatment programs (whether or not the program is part of a Residential Treatment Facility or otherwise licensed institution)
- Job training
- Job hardening programs

- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

9. Examinations. Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy coverage or to get or keep a license.
- To travel
- To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

10. Experimental or Investigational. Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trials.

11. Foot care. Routine services and supplies for the following:

- Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails
- Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
- Treatment of calluses, bunions, toenails, hammertoes or fallen arches
- Treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes

12. Foot orthotic devices. Foot orthotics or other devices to support the feet, such as arch supports and shoe inserts, unless required for the treatment of or to prevent complications of diabetes.

13. Growth/height care.

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth

- Surgical Procedures, devices and growth hormones to stimulate growth

14. Hearing aids. Any tests, appliances and devices to:

    - Improve your hearing
    - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

15. Hearing exams. Hearing exams performed for the evaluation and treatment of illness, injury or hearing loss.

16. Maintenance care. Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services.

17. Medical supplies – outpatient disposable. Any outpatient disposable supply or device. Examples of these include:

    - Sheaths
    - Bags
    - Elastic garments
    - Support hose
    - Bandages
    - Bedpans
    - Home test kits not related to diabetic testing
    - Splints
    - Neck braces
    - Compresses
    - Other devices not intended for reuse by another patient

18. Missed appointments. Any cost resulting from a canceled or missed appointment.

19. Nutritional support. Any food item, including:

    - Infant formulas, except for infant formula needed for the treatment of inborn errors of metabolism
    - Nutritional supplements

- Vitamins
- Prescription vitamins
- Medical foods
- Other nutritional items

20. Obesity Surgery and services. Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Coverage and Exclusions* section of this Part II, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:

    - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric Surgery
    - Surgical Procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
    - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
    - Hypnosis, or other forms of therapy
    - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

21. Oral and maxillofacial (treatment of mouth, jaws and teeth). Surgical and non-surgical medical, dental, diagnostic or therapeutic services related to treatment of the mouth, jaws and teeth, except as specifically provided in the *Coverage and Exclusions* section of this Part II.

22. Other non-Covered Services.

    - Services you have no legal obligation to pay
    - Services that would not otherwise be charged if you did not have the coverage under the Plan

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

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

25. Prescription or non-Prescription drugs and medicines - outpatient. Drugs that are included on the list of Specialty Prescription Drugs as covered under your outpatient Prescription drug benefit.

26. Routine exams. Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Coverage and Exclusions* section of this Part II.

27. Services provided by a family member. Services provided by a spouse, civil union partner, domestic partner, parent, child, stepchild, brother, sister, in- law, or any household member.

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

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

    - Surgery, Prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
    - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

30. Strength and performance. Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance.

31. Telemedicine.

    - Services given when you are not present at the same time as the Provider
    - Services including:
        - Telephone calls
        - Telemedicine kiosks
        - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

32. Therapies and tests.

    - Full body CT scans
    - Hair analysis

- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

33. Tobacco cessation. Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:

    - Counseling, except as specifically provided in the *Coverage and Exclusions* section of this Part II
    - Hypnosis and other therapies
    - Medications, except as specifically provided in the *Coverage and Exclusions* section of this Part II
    - Nicotine patches
    - Gum

34. Treatment in a federal, state, or governmental entity. Any care in a Hospital or other facility owned or operated by any federal, state or other governmental entity unless coverage is required by applicable laws.

35. Voluntary sterilization. Reversal of voluntary sterilization procedures, including related follow-up care.

36. Wilderness treatment programs. See *Educational services* in this section.

37. Work related illness or injuries. Coverage available to you under workers' compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment.

38. Services not permitted under applicable state or local laws. Some state or local laws restrict the scope of health care services that a Provider may render. In such cases, the Plan will not cover such health care services.

    Important note: A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

How your Plan works.

1. How your medical benefit works while you are covered in-network. Your in-network coverage:

   - Helps you get and pay for a lot of – but not all – health care services Your cost share is lower when you use a Network Provider.

   Our Provider network is there to give you the care you need. You can find Network Providers and see important information about them by logging in to your member website at http://www.aetna.com. There you'll find our online Provider directory.

   You may choose a PCP to oversee your care. Your PCP will provide routine care and send you to other Providers when you need specialized care. You don't have to get care through your PCP. You may go directly to Network Providers. Your Plan may pay a bigger share for Covered Services you get through your PCP, so choose a PCP as soon as you can.

   For more information about the network and the role of your PCP, see the *Who provides the care* section below.

   Your Plan generally pays for Covered Services only within a specific geographic area, called a service area. There are some exceptions, such as for Emergency Services, urgent care, and transplant services.

2. How your medical benefit works while you are covered out-of-network. With your out-of-network coverage:

   - You can get care from Providers who are not part of the Aetna network and from Network Providers without a PCP referral
   - You may have to pay the full cost for your care, and then submit a claim to be reimbursed
   - You are responsible to get any required precertification
   - Your cost share will be higher

   You may have to find a new Provider when:

   - You join the Plan and the Provider you have now is not in the network
   - You are already an Aetna member and your Provider stops being in our network

   However, in some cases, you may be able to keep going to your current Provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

   If this situation applies to you, contact us at 1-888-290-7241 for details. If we approve your request to keep going to your current Provider, we will tell you how long you can continue

to see the Provider. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery.

We will authorize coverage only if the Provider agrees to our usual terms and conditions for contracting Providers.

3. Who provides the care. We have contracted with Providers in the service area to provide Covered Services to you. These Providers make up the network for your Plan.

   To get network benefits, you must use Network Providers. There are some exceptions:

   - Emergency Services – see the description of *Emergency Services* in the *Coverage and Exclusions* section of this Part II.
   - Urgent care – see the description of *Urgent care services* in the *Coverage and Exclusions* section of this Part II.
   - Transplants – see the description of *Transplant services* in the *Coverage and Exclusions* section of this Part II.

   You may select a Network Provider from the online directory through your member website at http://www.aetna.com.

   You will not have to submit claims for services received from Network Providers. Your Network Provider will take care of that for you. And we will pay the Network Provider directly for what the Plan owes.

   We encourage you to get Covered Services through a PCP. They will provide you with primary care.

   You can choose a PCP from the list of PCPs in our directory.

   Each covered family member is encouraged to select a PCP. You may each choose a different PCP. You should select a PCP for your covered dependent if they are a minor or cannot choose a PCP on their own.

   Your PCP will coordinate your medical care or may provide treatment. They may send you to other Network Providers.

   You may change your PCP at any time by contacting us.

4. Medical Necessity and precertification requirements. Your Plan pays for its share of the expense for Covered Services only if the general requirements are met. They are:

   - The service is Medically Necessary
   - For in-network benefits, you get the service from a Network Provider

- You or your Provider precertifies the service when required

(a) Medically Necessary, Medical Necessity. The Medical Necessity requirements are in the *Glossary* section of this Part II, where we define "Medically Necessary, Medical Necessity." That is where we also explain what our medical directors or a Physician they assign consider when determining if a service is Medically Necessary.

The Medical Necessity review for certain services and procedures may include sequenced treatment requirements, which refers to use of the most effective form of treatment first, before other treatments may be approved.

The Medical Necessity review is sometimes referred to using any of the following terms depending on the benefits subject to review and when the review is performed:

- Precertification (pre-approval or pre-service) review is generally a Medical Necessity review that must be performed before you obtain services.

- Concurrent review is a Medical Necessity review required in order to extend a previously approved course of treatment (for example, if a pre-approved Hospital Stay needs to be extended); and

- Retrospective (post-service) review is a Medical Necessity review that is performed with respect to certain out-of-network benefits after treatment has already been provided.

We generally use the term precertification throughout this booklet to refer to these Medical Necessity reviews. Refer to the *Precertification* information below for additional information.

Important note: We cover Medically Necessary, sex-specific Covered Services regardless of identified gender.

(b) Precertification. You need pre-approval from us for some Covered Services. Pre-approval is also called precertification (or pre-service review).

Your network Physician is responsible for obtaining any necessary precertification before you get the care. Network Providers cannot bill you if they fail to ask us for precertification. But if your Physician requests precertification and we deny it, and you still choose to get the care, you will have to pay for it yourself.

When you go to an Out-of-Network Provider, you are responsible to get any required precertification from us. If you don't precertify:

- Your benefits may be reduced, or the Plan may not pay. See the *Schedule of Benefits* in this Part II for details.

- You will be responsible for the unpaid bills.
- Your additional out-of-pocket expenses will not count toward your deductible or maximum out-of- pocket limit, if you have any.

Timeframes for precertification are listed below. For Emergency Services, precertification is not required, but you should notify us as shown.

To obtain precertification, contact us at 1-888-290-7241. You, your Physician or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted
Urgent admission	Call before you are scheduled to be admitted
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment or procedure is scheduled

An urgent admission is a Hospital admission by a Physician due to the onset of or change in an illness, the diagnosis of an illness, or injury.

We will tell you and your Physician in writing of the precertification decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the Plan.

For an inpatient Stay in a facility, we will tell you, your Physician and the facility about your precertified length of Stay. If your Physician recommends that you Stay longer, the extra days will need to be precertified (this is also called concurrent review). You, your Physician, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your Physician in writing of an approval or denial of the extra days.

If you or your Provider request precertification and we don't approve coverage, we will tell you why and explain how you or your Provider may request review of our decision. See the *Claim decisions and appeal procedures* section of this Part II.

Precertification is required for the following types of services and supplies:

Inpatient services and supplies	Outpatient services and supplies
Stays in a Hospital	Complex imaging
Stays in a Skilled Nursing Facility	Reconstructive Surgery
Stays in a rehabilitation facility	Transportation by airplane
Stays in a Residential Treatment Facility for treatment of Mental Health Disorders and Substance Related Disorders	Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
	Kidney dialysis
	Outpatient back Surgery not performed in a Physician's office
	Private duty nursing services
	Sleep studies
	Knee Surgery
	Wrist Surgery
	Transcranial magnetic stimulation (TMS)
	Partial Hospitalization treatment – Mental Health Disorders and Substance Related Disorders treatment diagnoses
	Applied behavior analysis (ABA)

Contact us to get a list of the services that require precertification. The list may change from time to time.

Sometimes you or your Provider may want us to review a service that doesn't require precertification before you get care. This is called a predetermination, and it is different from precertification. Predetermination means that you or your Provider requests the pre-service clinical review of a service that does not require precertification.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help guide individualized coverage decisions under our plans. You can find the bulletins and other information at https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html.

Certain Prescription drugs are covered under the medical benefit when they are given to you by your doctor or health care facility. The following precertification information applies to these Prescription drugs:

For certain drugs, your Provider needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are Medically Necessary.

Contact us at 1-888-290-7241 or go online to http://www.aetna.com to get the most up-to-date precertification requirements.

5. What the Plan pays and what you pay. The Schedule of Benefits located in this Part II lists what the Plan pays for each type of Covered Service. In general, this is how your benefit works:

- Then the Plan and you share the expense. Your share is called a Coinsurance.
- Then the Plan pays the entire expense after you reach your maximum out-of-pocket limit.

When we say "expense" in this general rule, we mean the Negotiated Charge for a Network Provider, and Recognized Charge for an Out-of-Network Provider.

(a) Negotiated Charge for health coverage. This is the amount a Network Provider has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid).

Some Providers are part of Aetna's network for some Aetna plans but are not considered Network Providers for your Plan. For those Providers, the Negotiated Charge is the amount that Provider has agreed to accept for rendering services or providing Prescription drugs to members of your Plan.

We may enter into arrangements with Network Providers or others related to:

- The coordination of care for members
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing
- Accountable care arrangements

These arrangements will not change the Negotiated Charge under the Plan.

(b) Negotiated Charge for Prescription drug services. When you get a Prescription drug, we have agreed to this amount for the Prescription or paid this amount to the network pharmacy or third party vendor that provided it. The Negotiated Charge may include a rebate, additional service or risk charges and administrative fees. It

may include additional amounts paid to or received from third parties under price guarantees.

(c) Recognized Charge. The amount of an Out-of-Network Provider's charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

Your cost may be lower when you get care from a National Advantage Program (NAP) Provider. Through NAP, the Recognized Charge is determined as follows:

- If your service was received from a NAP Provider, a pre-Negotiated Charge will be paid. NAP Providers are Out-of-Network Providers that have contracts with Aetna, directly or through third-party vendors, that include a pre-Negotiated Charge for services. NAP Providers are not Network Providers.

- If your service was not received from a NAP Provider, a claim specific rate or discount may be negotiated by Aetna or a third-party vendor.

If your claim is not paid as outlined above, the Recognized Charge for specific services or supplies will be the out- of-network plan rate, calculated in accordance with the following:

Service or Supply	Out-of-Network Plan Rate
Professional services	An amount determined by Aetna, or its third-partyvendors, based on data resources selected by Aetna, reflecting typical competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.
Inpatient and outpatient charges of Hospitals	Facility Charge Review
Inpatient and outpatient charges of facilities other than Hospitals	
Prescription drugs	110% of the average wholesale price (AWP)

Important note: If the Provider bills less than the amount calculated using the out-of-network plan rate described above, the Recognized Charge is what the Provider bills.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by an Out-of-Network Provider, unless that Out-of-Network Provider is an assistant surgeon for your Surgery
- Not available from a Network Provider
- Emergency Services

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a Network Provider.

(d) Special terms used:

- Average wholesale price (AWP) is the current average wholesale price of a Prescription drug listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by Aetna).
- Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility Provider's estimated costs for the service and leave the facility Provider with a reasonable profit. For Hospitals and other facilities that report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. We may adjust the formula as needed to maintain the reasonableness of the Recognized Charge. For example, we may make an adjustment if we determine that in a particular state the charges of ambulatory Surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.
- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

(e) Our reimbursement policies. We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the Recognized Charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included

- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the Provider

Our reimbursement policies may consider:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of Physicians and dentists practicing in the relevant clinical areas
- Aetna's own data and/or databases and methodologies maintained by third parties.

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

6. Paying for Covered Services – the general requirements. There are several general requirements for the Plan to pay any part of the expense for a Covered Service. For in-network coverage, they are:

- The service is Medically Necessary
- You get your care from a Network Provider
- You or your Provider precertifies the service when required

For out-of-network coverage:

- The service is Medically Necessary
- You get your care from an Out-of-Network Provider
- You or your Provider precertifies the service when required

For outpatient Prescription drugs, your costs are based on:

- The type of Prescription you're prescribed
- Where you fill the Prescription

The Plan may make some Brand-Name Prescription Drugs available to you at the Generic Prescription Drug cost share.

Generally, your Plan and you share the cost for Covered Services when you meet the general requirements. But sometimes your Plan will pay the entire expense, and sometimes you will. For details, see the *Schedule of Benefits* in this Part II and the information below.

You pay the entire expense when:

- You get services or supplies that are not Medically Necessary.
- Your Plan requires precertification, your Physician requests it, we deny it and you get the services without precertification.
- You get care from an Out-of-Network Provider and the Provider waives all or part of your cost share.

In all these cases, the Provider may require you to pay the entire charge. Any amount you pay will not count towards your maximum out-of-pocket limit.

7. Coordination of benefits. Refer to the *Coordination of Benefits* section of Part I for coordination of benefits information provided by the Plan Administrator.

8. Benefit payments and claims. A claim is a request for payment that you or your health care Provider submits to us when you want or get Covered Services. There are different types of claims. You or your Provider may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

   It is important that you carefully read the previous sections within *How your Plan works*. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

   Refer to the *Claim decisions and appeals procedures* section of this Part II and to the *Claims and Appeals Procedures* section of Part V for additional Claims information provided by the Plan Administrator.

   When you see a Network Provider, that office will usually send us a detailed bill for your services. If you see an Out-of-Network Provider, you may receive the bill (proof of loss) directly. This bill forms the basis of your post- service claim. If you receive the bill directly, you should send it to us as soon as possible with a claim form that you can either get online at http://www.aetna.com or contact us at 1-888-290-7241 to provide. You should always keep your own record of the date, Providers and cost of your services.

   The benefit payment determination is made based on many things, such as your Coinsurance, the necessity of the service you received, when or where you receive the

services, or even what other insurance you may have. We may need to ask you or your Provider for some more information to make a final decision. You can always contact us directly at 1-888-290-7241 to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. We may even rescind your coverage entirely. Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Claim decisions and appeals procedures* section of this Part II below for that information.

Claim decisions and appeals procedures.
Refer to Part V for Claims and appeals procedures information provided by the Plan Administrator.

1. Recordkeeping. We will keep the records of all complaints and appeals for at least 10 years.

2. Fees and expenses. We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

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

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

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

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

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

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

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

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

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

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

7. Applicability to All Settlements and Judgments. The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless

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

8. Cooperation. You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You and your agents agree to provide the Plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Plan Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

   You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of the Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the health Plan's subrogation and reimbursement interest.

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

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

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

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

Glossary.
For purposes of the description of the Aetna Health Care Benefits in this Part II, the following definitions shall apply:

1. Behavioral Health Provider. A Health Professional who is licensed or certified to provide Covered Services for mental health and Substance Related Disorders in the state where the person practices.

2. Brand-Name Prescription Drug. An FDA-approved drug marketed with a specific name by the company that manufactures it; often the same company that developed and patents it.

3. Coinsurance. Coinsurance is the percentage you pay for a Covered Service.

4. Covered Service. The benefits, subject to varying cost shares, covered in the Plan. These are:

    - Described in the Providing Covered Services section
    - Not listed as an exclusion in the Coverage and exclusions – Providing Covered Services section or the General Plan exclusions section
    - Not beyond any limits in the schedule of benefits
    - Medically Necessary. See the *Medical Necessity and precertification requirements* and the *Glossary* in this Part II for more information

5. Detoxification. The process of getting alcohol or other drugs out of an addicted person's system and getting them physically stable.

6. Drug Guide. A list of Prescription drugs and devices established by us or an affiliate. It does not include all Prescription drugs and devices. This list can be reviewed and changed by us or an affiliate. A copy is available at your request. Go to https://www.aetna.com/individuals-families/find-a-medication.html.

7. Emergency Medical Condition. A severe medical condition that:

    - Comes on suddenly
    - Needs immediate medical care

- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could result in:
  - Danger to life or health
  - Loss of a bodily function
  - Loss of function to a body part or organ
  - Danger to the health of an unborn baby

8. Emergency Services. Treatment given in a Hospital's emergency room. This includes evaluation of and treatment to stabilize the Emergency Medical Condition.

9. Experimental or Investigational. Drugs, treatments or tests not yet accepted by Physicians or by insurance plans as standard treatment. They may not be proven as effective or safe for most people. A drug, device, procedure, or treatment is Experimental or Investigational if:
   - There is not enough outcome data available from controlled clinical trials published in the peer- reviewed literature to validate its safety and effectiveness for the illness or injury involved.
   - The needed approval by the FDA has not been given for marketing.
   - A national medical or dental society or regulatory agency has stated in writing that it is Experimental or Investigational or suitable mainly for research purposes.
   - It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
   - Written protocols or a written consent form used by a facility Provider state that it is Experimental or Investigational.

10. Formulary Exclusions List. A list of Prescription drugs not covered under the Plan. This list is subject to change.

11. Generic Prescription Drug. An FDA-approved drug with the same intended use as the brand-name product. It offers the same:
    - Dosage
    - Safety
    - Strength

- Quality
- Performance

12. Health Professional. A person who is authorized by law to provide health care services to the public; for example, Physicians, nurses and physical therapists.

13. Home Health Care Agency. An agency authorized by law to provide home health services, such as skilled nursing and other therapeutic services.

14. Hospital. An institution licensed as a Hospital by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can Stay overnight for care. Or they can be treated and leave the same day. All Hospitals must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

15. Infertile, Infertility. A disease defined by the failure to become pregnant:

- For a female with a male partner, after:
  - 1 year of frequent, unprotected heterosexual sexual intercourse if under the age of 35
  - 6 months of frequent, unprotected heterosexual sexual intercourse if age 35 or older
- For a female without a male partner, after:
  - At least 12 cycles of donor insemination if under the age of 35
  - 6 cycles of donor insemination if age 35 or older
- For a male without a female partner, after:
  - At least 2 abnormal semen analyses obtained at least 2 weeks apart
- For an individual or their partner who has been clinically diagnosed with gender identity disorder.

16. Institutes of Quality® (IOQ) (Cardiac). A national network of facilities publicly recognized, high-quality, high-value health care Providers. These Providers offer access to a quality and efficient network for specific procedures. The Institutes have met extensive quality, as well as efficiency criteria. IOQ Cardiac Care services include Cardiac Medical Intervention, Heart Surgery and Heart Rhythm Disorders.

17. Jaw Joint Disorder. This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

18. Mail Order Pharmacy. A pharmacy where Prescription drugs are legally dispensed by mail or another carrier.

19. Maximum Out-of-Pocket Limit. The maximum out-of-pocket limit is the most a covered person will pay per year in Coinsurance, if any, for Covered Services.

20. Medically Necessary, Medical Necessity. Health care services that we determine a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that we determine are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, Physician or other health care Provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Following the standards set forth in our clinical policies and applying clinical judgment

21. Mental Health Disorder. A Mental Health Disorder is in general, a set of symptoms or behavior associated with distress and interference with personal function. A complete definition of Mental Health Disorder is in the most recent edition of Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association.

22. Negotiated Charge. See the *What the Plan pays and what you pay* section of this Part II.

23. Network Provider. A Provider listed in the directory for your Plan. A NAP Provider listed in the NAP directory is not a Network Provider. A Network Provider can also be referred to as an in-Network Provider.

24. Out-of-Network Provider. A Provider who is not a Network Provider.

25. Physician. A Health Professional trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a Physician can also be a Primary Care Physician (PCP).

26. Preferred Drug. A Prescription drug or device that may have a lower out-of-pocket cost than a non-preferred drug.

27. Prescription. This is an instruction written by a Physician that authorizes a patient to receive a service, supply, medicine or treatment.

28. Primary Care Physician (PCP). A Physician who:

    - The directory lists as a PCP
    - Is selected by a covered person from the list of PCPs in the directory
    - Supervises, coordinates and provides initial care and basic medical services to a covered person
    - Shows in our records as your PCP

    A PCP can be any of the following Providers:

    - General practitioner
    - Family Physician
    - Internist
    - Pediatrician
    - OB, GYN, and OB/GYN
    - Medical group (primary care office)

29. Provider. A Physician, Health Professional, person, or facility, licensed or certified by law to provide health care services to you. If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare.

30. Psychiatric Hospital. An institution licensed or certified as a Psychiatric Hospital by applicable laws to provide a program for the diagnosis, evaluation, and treatment of

alcoholism, drug abuse or Mental Health Disorders (including Substance Related Disorders).

31. Recognized Charge. See the *What the Plan pays and what you pay* section of this Part II.

32. Residential Treatment Facility. An institution specifically licensed as a Residential Treatment Facility by applicable laws to provide for mental health or Substance Related Disorder residential treatment programs. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following:

(a) For residential treatment programs treating Mental Health Disorders:

- A Behavioral Health Provider must be actively on duty 24 hours/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed Residential Treatment Facility or otherwise licensed institution)

(b) For residential treatment programs treating Substance Related Disorders:

- A Behavioral Health Provider or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a Physician
- It is not a wilderness treatment program (whether or not the program is part of a licensed Residential Treatment Facility or otherwise licensed institution)

(c) For Detoxification programs within a residential setting:

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting
- Residential care must be provided under the direct supervision of a Physician

33. Retail Pharmacy. A community pharmacy that dispenses outpatient Prescription drugs at retail prices.

34. Room and Board. A facility's charge for your overnight Stay and other services and supplies expressed as a daily or weekly rate.

35. Semi-Private Room Rate. An institution's Room and Board charge for most beds in rooms with 2 or more beds. If there are no such rooms, we will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

36. Skilled Nursing Facility. A facility specifically licensed as a Skilled Nursing Facility by applicable laws to provide skilled nursing care. Skilled nursing facilities also include:

- Rehabilitation Hospitals
- Portions of a rehabilitation Hospital
- A Hospital designated for skilled or rehabilitation services

Skilled Nursing Facility does not include institutions that provide only:

- Minimal care
- Custodial care
- Ambulatory care
- Part-time care

It does not include institutions that primarily provide for the care and treatment of Mental Health Disorders or Substance Related Disorders.

37. Skilled Nursing Services. Services provided by a registered nurse or licensed practical nurse within the scope of their license.

38. Specialist. A Physician who practices in any generally accepted medical or surgical sub-specialty.

39. Specialty Prescription Drugs. These are Prescription drugs that include typically high-cost drugs that require special handling, special storage or monitoring and may include things such as oral, topical, inhaled and injected routes of administration. You can contact us at 1-888-290-7241 to access the list of specialty drugs.

40. Specialty Pharmacy. This is a pharmacy designated by us as a network pharmacy to fill Prescriptions for Specialty Prescription Drugs.

41. Stay. A full-time inpatient confinement for which a Room and Board charge is made.

42. Substance Related Disorder. This is a physical or psychological dependency, or both, on a drug or alcohol. These are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include an addiction to nicotine products, food or caffeine.

43. Surgery, Surgical Procedure. The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution
- Otherwise physically changing body tissues and organs

44. Telemedicine. A consultation between you and a Provider who is performing a clinical medical or behavioral health service that can be provided electronically by:

- Two-way audiovisual teleconferencing
- Telephone calls

- Any other method required by law

45. Terminal Illness. A medical prognosis that you are not likely to live more than 12 months.

46. Urgent Condition. An illness or injury that requires prompt medical attention but is not a life-threatening Emergency Medical Condition.

47. Walk-In Clinic. A health care facility that provides limited medical care on a scheduled and unscheduled basis. A Walk-In Clinic may be located in, near or within a:

    - Drug store
    - Pharmacy
    - Retail store
    - Supermarket

    The following are not considered a Walk-In Clinic:

    - Ambulatory surgical center
    - Emergency room
    - Hospital
    - Outpatient department of a Hospital
    - Physician's office
    - Urgent care facility

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of Stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter Stay if the attending Provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, the Plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) Stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the Stay.

In addition, the Plan may not, under federal law, require that you, your Physician, or other health care Provider obtain authorization for prescribing a length of Stay of up to 48 hours (or 96 hours).

However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours).

Notice Regarding Women's Health and Cancer Rights Act
Under the Plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- All stages of reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending Physician and the patient, and will be provided in accordance with the Plan design, limitations, Coinsurance, and referral requirements, if any, as outlined in the Plan.

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

- **Acquiring a new dependent.** If you acquire a new dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for yourself and your dependents. Enrollment of dependent children is limited to the newborn or adopted children or children who became dependent children of the employee due to marriage.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously

declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:

- divorce or legal separation;
- cessation of dependent status (such as reaching the limiting age);
- death of the employee;
- termination of employment;
- reduction in work hours to below the minimum required for eligibility;
- you or your dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
- you or your dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
- the other plan no longer offers any benefits to a class of similarly situated individuals.

- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the employee's or dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible dependent(s).

- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected dependent(s) who are not

already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as described in Part I of this booklet regarding the special rules that apply to newborn children and newly acquired spouses, special enrollment generally must be requested within 30 days after the occurrence of the special enrollment event. Subject to those special rules in Part I, if the special enrollment event is the birth or adoption of a dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

PART III

DENTAL BENEFITS

The Plan's Dental Benefits described in Part III of this booklet are administered by Delta Dental of Kansas, Inc. Any claims filed for dental benefits or any questions you have regarding these benefits should be addressed to Delta Dental of Kansas, Inc., P.O. Box 789769, Wichita, Kansas, 67278-9769. Or, you can visit Delta Dental at 1619 North Waterfront Parkway, Wichita, Kansas 67206. The telephone number is 1-800-733-5823 or 1-800-234-3375. You may also access the Delta Dental network nationwide, through its website at www.deltadentalks.com.

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

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

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

How to Use Your Dental Benefits
There are no pre-examination requirements for you or your dependents to be eligible for dental benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Employee group number and identification number.

2. Patient name and birth date.

3. Dentist name and license number.

4. Claim number.

5. Date(s) of service.

6. An explanation of the complaint or question.

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

Telephone inquiries may be directed to the following numbers: in Wichita, 1-800-733-5823, or outside of the Wichita area, 1-800-234-3375.

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

You may also telephone the Customer Service Department using any of the numbers identified above. Complaints or inquiries may also be presented in person at the business office of Delta Dental of Kansas, Inc., which is located at 1619 North Waterfront Parkway, Wichita, Kansas 67206.

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

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

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

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

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

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

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

1. "Cosmetic Surgery" means those services provided by Dentists for the purpose of improving the oral appearance when the form and function are otherwise satisfactory. The determination of whether services are "Cosmetic" shall be made by Delta Dental in its discretion.

2. "Covered Dental Services" means those dental services, procedures, and products that are covered by Delta Dental, in whole or in part, pursuant to the terms of the Plan.

3. "Dentist" means any duly licensed dentist or other duly licensed person who performs the service for which the payment may be made by Delta Dental under the terms of the Plan if such service is performed with the lawful scope of that person's license.

4. "Injury" means physical or traumatic damage or harm, accidental in its origin and character, in the sense that it is the result of a sudden mishap occurring by chance, unexpectedly, and not in the usual course of events, at a particular time and place.

5. "Participating Dentist" means any duly licensed person legally entitled to practice dentistry at the time and in the place the dental services are performed and who has agreed to render

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

6. "Maximum Plan Allowance" shall be defined as the lesser of the following:

   (a) Participating Dentist:

      (i) the fee submitted by the Participating Dentist for the dental procedure;

      (ii) the fee that such Participating Dentist has filed with Delta Dental for the dental procedure, if any; or

      (iii) the Delta Dental Participating Dentist Maximum Fee.

   (b) Non-Participating Dentist:

      (i) the fee submitted by the Non-Participating Dentist for the dental procedure; or

      (ii) the Delta Non-Participating Dentist Maximum Fee.

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

Diagnostic and Preventive

100% I. DIAGNOSTIC: Includes the following procedures necessary to evaluate existing dental conditions and the dental care required:

- Oral evaluations – once each six months.
- Bitewing x-rays – bitewings once each six months for dependents under age 18 and once each 12 months for adults age 18 and over.

80% II. X-RAYS: Provides for the following:

- Diagnostic x-rays – intraoral periapical, unlimited frequency.
- Full mouth or panoramic x-rays – once each five years.

100% III. PREVENTIVE: Provides for prophylaxis (cleanings) – once each six months.

80% IV. PREVENTIVE: Provides for the following:

- Topical Fluoride – once each six months for dependent children under age 19.

- Space Maintainers for dependent children under age 14 and only for premature loss of primary molars.

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

Basic

80% V. ANCILLARY: Provides for emergency examination(s) by the Dentist for the relief of pain.

80% VI. ORAL SURGERY: Provides for extractions and other oral surgery including pre- and post-operative care.

80% VII. REGULAR RESTORATIVE DENTISTRY: Provides amalgam (silver) restorations, composite (white) resin restorations; and stainless steel crowns for dependents under age 12.

80% VIII. ENDODONTICS: Includes procedures for root canal treatments and root canal fillings. When covered, payment for root canal therapy is limited to only once in any 24-month period, per tooth.

80% IX. PERIODONTICS: Includes the following:

- Procedures for the treatment of diseases of the tissues supporting the teeth. Periodontal maintenance, including evaluation, is counted toward the frequency limitation for prophylaxis cleanings.

- Surgical periodontal procedures.

Major

50% X. SPECIAL RESTORATIVE DENTISTRY: When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for individual crowns.

50% XI. PROSTHODONTICS: Includes the following:

- Bridges, partial and complete dentures.

- Repairs and adjustments of bridges and dentures.

- Implants.

Orthodontics

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

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

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

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

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

A. Coverage for any patient who has been, but no longer is, a participant in the Plan.

B. Benefits or services for injuries or conditions compensable under worker's compensation or employer's liability laws; or benefits or services which are available from any federal or state government agency, or similar entity.

C. Benefits, services, or appliances which are determined by Delta Dental to be for cosmetic purposes.

D. Benefits, services or appliances, including but not limited to prosthodontics, including crowns and bridges, started prior to the date the patient became eligible for benefits hereunder.

E. Prescription drugs, premedications and relative analgesia, including nitrous oxide; hospital, healthcare facility, or medical emergency room charges; laboratory charges; anesthesia for restorative dentistry; and preventive control programs.

F. Charges for failure to keep a scheduled visit and charges for completion of forms.

G. Appliances or restorations for altering vertical dimension; restoring occlusion; replacing tooth structure lost by attrition, abrasion, bruxism, erosion abfraction, or corrosion; for splinting or equilibration.

H. Dental care injuries or disease caused by riots or any form of civil disobedience if the claimant was a participant therein; war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of

war whether voluntarily or as required by an employer; injuries sustained while in the act of committing a criminal act; and injuries intentionally self-inflicted.

I. Temporary services and procedures, including, but not limited to, temporary prosthetic devices.

J. Any dental services, procedures, or products for which no benefit is provided, in whole or in part, under the terms of the Agreement between Delta Dental and the Fund.

K. Crowns and endodontic treatment in conjunction with an over denture.

L. Replacement of lost or stolen dentures or charges for duplicate dentures.

M. No benefits are payable for accidental bodily injuries arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used-including such benefits mandated by law) of any automobile policy.

N. Any benefit, procedure or service, to treat, modify, correct or change an existing condition or status caused or contributed to by prior medical or dental treatment, when prior treatment was performed in accordance with then generally accepted standards of medicine or dentistry in the local community where performed.

O. Dental benefits and services which are not completed.

P. Treatment rendered outside of the United States or Canada.

Q. Services performed for the purpose of full mouth reconstruction are not Covered Dental Services unless shown as a Covered Dental Service in the List of Dental Benefits. For example, extensive treatment plans involving 10 or more crowns or units of fixed bridgework are considered full mouth reconstruction.

R. Benefits or services for control of harmful habits.

S. Diagnosis or treatment of temporomandibular joint dysfunction.

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

A. If a more expensive Covered Dental Service is provided than Delta Dental determines to be the least costly professionally accepted treatment, Delta Dental will pay the applicable benefit for the Covered Dental Service which is needed to achieve reasonable functionality.

B. Only the costs of the procedures necessary to prevent or eliminate oral disease and for appliances or restorations required to replace missing teeth are covered under the Plan, and then only if specifically included as a Covered Dental Service in the List of Dental Benefits.

C. Bitewings taken within 12 months of a full mouth series of x-rays will be disallowed.

D. A panoramic film in conjunction with a full mouth series of x-rays is not a separate benefit.

E. A seven vertical bitewing series is limited to once every two years.

F. Restoration of surfaces on teeth are limited to only once or twice within a 24-month period dependent upon the anatomy of the tooth. Restorations on the same tooth done within 24 months after a crown is seated are subject to frequency limitations.

G. Recementation of space maintainers are limited to once per arch or quadrant per lifetime.

H. Inlays will automatically receive benefits equal to the corresponding surface of a filling.

I. Individual crowns are limited as follows:

1. Individual crowns on the same tooth are limited to only once in any five-year period unless needed because of Injury. This time period is to be measured from the date the crown was supplied. If a crown is placed on a tooth which has had a restoration in the previous 24-month period, benefits paid for the crown are reduced by the benefit paid for the prior restoration.

2. Porcelain crowns, porcelain fused to metal, or resin processed to metal type crowns are not covered for any person under 12 years of age.

3. Recementation of a crown is limited to only once in a lifetime.

4. Repairs per crown are limited to two in a 12-month period.

5. Stainless steel crowns are limited to once in a 24-month period when placed on a primary tooth. If used as a permanent crown, the limitations of subparagraphs 1; 2; 3; and 4 of this subsection I will apply.

6. Core build-ups, including pins, are limited to permanent teeth having insufficient tooth structure to build a crown.

J. Prosthodontics are limited as follows:

1. Not more than one full upper and one full lower denture shall be constructed in any five-year period for any one person. This time period is to be measured from the date the denture was last supplied to the person.

2. A removable prosthetic or fixed prosthetic device, including bridges or implants, or full upper or full lower dentures, may not be provided for any person more often than once in any five-year period. This time period is to be measured from the last date of service the removable prosthetic or fixed prosthetic device, including bridges or implants, or full upper or full lower dentures was last supplied.

3. Denture reline and rebase is limited to only once in any 36-month period for any one person.

4. Denture adjustments are limited to only two times in any 12-month period for any one person.

5. Crowns when used for abutment purposes are covered at the same co-payment percentage as provided under the Plan for bridges and complete and partial dentures.

6. Recementation of a bridge is limited to only once in a lifetime.

7. If teeth are missing in both quadrants of the same arch, benefits are allowed for a bilateral partial towards the procedure submitted. If a fixed bridge or other more expensive procedure is selected, an allowance for a partial denture is made to restore the arch to contour and function.

8. Only two repairs per prosthesis, such as bridges, partials, or dentures, will be allowed in a 12-month period.

9. Tissue conditioning is limited to no more than two per arch each 36 months.

10. Dental implant procedures and associated services will be a Covered Dental Service, subject to the frequency in paragraph 2 above, and the following limitations:

    a. Coverage should be predetermined and is limited to those persons age 16 and over. They do not need to be totally edentulous, meaning there may still be natural teeth in the arch for which the dental implants are being contemplated.

    b. The Dentist should submit to Delta Dental a written report of recommended treatment setting forth the type and number of implants to be used, radiographs to support the dental necessity of the implant procedures as required by Delta Dental, and the proposed fees for the entire procedure.

    c. As determined by Delta Dental, the Covered Dental Services may include, but are not limited to, consultations and surgical placement of implant devices (including the associated device and/or prosthesis) provided in conjunction with the dental implant procedures.

    d. Payments are limited to the lesser of: (i) $1,500, or (ii) the amount determined by Delta Dental to be allowable for dentures that are conventionally constructed using standard procedures, and which are of the same magnitude, i.e. complete upper, complete lower or complete upper and lower, as appropriate.

K. Payment for periodontic procedures is limited to only once in any 24-month period for all non-surgical periodontal procedures with the exception of the full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subject to the same limitations and is limited to one per lifetime; periodontal maintenance which is limited to once in any

six-month period; and crown lengthening which carries no frequency limitation. For surgical periodontal procedures, when covered, payment is limited to only once in any 24-month period.

L. Payment for anesthesia and IV (intravenous) sedation is limited to only for surgical extractions which are Covered Dental Services and is limited to a maximum of one hour, per episode.

M. Orthodontic Services are Covered Dental Services, subject to the following limitations:

1. Plan benefits will cease on the date of termination if the treatment plan is terminated for any reason, or the person is no longer eligible for benefits before completion of the case. Treatment may be terminated by the Dentist, by written notification to Delta Dental and to the person, for lack of person interest and cooperation.

2. Related services, such as but not limited to, x-rays, extractions, and study models, shall be payable at the orthodontic co-insurance percentage.

3. The repair or replacement of an orthodontic appliance is not a Covered Dental Service.

4. Maximum Benefit for Orthodontic Services:

   a. Payment for Orthodontic Services shall be limited to $1,500. Payment for Orthodontic Services shall be made on a monthly basis as determined by the number of months of treatment established by the Dentist. Payment of initial fees may be made at the time of the treatment.

   b. If a deductible applies, Delta Dental shall not be obligated to pay for, or otherwise discharge, in whole or in part, any fee, up to the deductible.

   c. The Maximum Benefit for Orthodontic Services will be reduced by all amounts previously paid as orthodontics benefits by Delta Dental or by any other dental plan or arrangement.

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

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

Termination of Benefits

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

Coordination of Benefits

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

PART IV

SCHEDULE OF OTHER WELFARE BENEFITS PROVIDED DIRECTLY BY THE FUND

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

1. Death Benefits & AD&D.

2. Weekly Disability Benefits.

3. Vision Benefits.

CLAIMING BENEFITS PROVIDED DIRECTLY BY THE TRUST FUND

Initial Claim Determination. Weekly Disability Benefits, Vision Benefits, Death Benefits, and Accidental Death and Dismemberment Benefits will be paid directly from the Trust Fund, rather than through an insurance company. Claims should be submitted to the Third-Party Administrator on forms it will provide. You must submit a claim for these benefits within one year and 90 days after you received a service. A decision will be made on each claim within a reasonable time after it is received. We anticipate most claims will be approved, but if a claim is wholly or partially denied, the Plan's "Appeals Procedure," described in Part V of this booklet, will be utilized.

DEATH BENEFITS

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

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (AD&D)

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

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

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

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

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

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

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

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

SCHEDULE OF AD&D BENEFITS

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

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

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

WEEKLY DISABILITY BENEFITS

Only employees who have the Minimum Eligibility Amount in their Dollar Bank account to maintain coverage as described in the Section of this booklet titled **"Maintenance of Eligibility"** (except those making payments on their own behalf), or who are eligible for COBRA continuation coverage as described in the Section of this booklet titled **"Continuation of Coverage Under COBRA"** or coverage under a period of Qualified Uniformed Service as described in the Section of this booklet titled **"Continuation and Reinstatement of Coverage on Account of Qualified Uniformed Service,"** may receive weekly income benefits. Employees who make payments on their own behalf to the Plan in order to maintain the Minimum Eligibility Amount in their Dollar Bank account as described in the Section of this booklet titled "**Self-Contributions**," are not eligible to receive weekly income benefits. If you become totally disabled because of a non-occupational disability, and remain under the care of a doctor (M.D. or D.O.), you will receive the weekly benefits set out in the Schedule of Benefits. No benefit is payable for any period for which you are entitled to receive workers' compensation benefits. The benefit payable under this provision will be paid to you after the waiting period specified in the Schedule. For any separate period of disability, payments will continue until the total disability ends or you reach the end of the benefit period, whichever happens first.

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

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

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

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

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

SCHEDULE OF DISABILITY BENEFITS

Weekly Disability Benefit	
Occupational Disabilities	None
Non-Occupational Disabilities	$300* or 66-2/3% of weekly compensation, whichever is less

Waiting Period
Accident 7 days
Sickness 7 days

RETIREE BENEFIT PROGRAM

Effective January 1, 2010
Retirees and their spouses from age 60 to age 65 may elect to continue coverage under the Plan's Retiree Benefit Program, but only if they are covered by the Plan at the time they attain age 60. Participants in the Retiree Benefit Program will be entitled to the same benefits as actively working employees, including the Plan's Health Care Benefits, Vision Benefit, Dental Benefits, Life Insurance Benefit, and Accidental Death and Dismemberment Benefit. The level of coverage will be the same as that provided to active employees under the Plan. However, participants in the Retiree Benefit Program will not be entitled to the Plan's Weekly Disability Benefit.

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

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

* Weekly Disability payments are subject to FICA Tax.

under the Retiree Benefit Program will not be offered COBRA continuation coverage at the time he or she loses coverage under the Retiree Benefit Program.

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

VISION BENEFITS

The Plan will pay a vision benefit of up to $600 per family for vision expenses each calendar year. Claim forms are available from the Third-Party Administrator or online at www.bmgiweb.com/441. A copy of the lens prescription, and an itemized statement must be submitted to the Third-Party Administrator with the claim form.

This benefit covers:

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

PART V

CLAIMS AND APPEALS PROCEDURES

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

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

CLAIMS PROCEDURES CHART

<table>
<tr><th rowspan="2"></th><th colspan="3">Where to File Claims</th><th rowspan="2">Filing Deadlines</th><th rowspan="2">Notification of Benefit Determination</th></tr>
<tr><th>Benefits Administered by Aetna</th><th>Dental Benefits</th><th>All Other Benefits</th></tr>
<tr><td>Urgent Care Claim[1]</td><td rowspan="4"><u>Medical</u>
Aetna
P.O. Box 14079
Lexington, KY 40512-4079
(888) 290-7241

Aetna
P.O. Box 981106
El Paso, TX 79998-1106
(888) 290-7241

<u>Prescription Drug</u>
Aetna Pharmacy Management
P.O. Box 52444
Phoenix, AZ 85072-2444
(888) 290-7241

<u>Mail Order Pharmacy</u>
CVS Caremark
P.O. Box 659541
San Antonio, TX 78265-9541
(800) 227-5720</td><td rowspan="4">Delta Dental of Kansas, Inc.
P.O. Box 49198
Wichita, KS 67201-9198
(800) 733-5823
or
(800) 234-3375</td><td rowspan="4">Third-Party Administrator
529 S Anna Street
Suite B
Wichita, KS 67209
(316) 264-2339</td><td>Before expense is incurred</td><td>Generally, not later than 72 hours after receipt of the claim</td></tr>
<tr><td>Pre-Service Claim[1]</td><td>Before expense is incurred</td><td>Not later than 15 days after receipt of the claim (may be extended an additional 15 days)</td></tr>
<tr><td>Post-Service Claim</td><td>Within one year and 90 days of the date the expense is incurred</td><td>Not later than 30 days after receipt of the claim (may be extended an additional 15 days)</td></tr>
<tr><td>Disability Claim</td><td>Within one year and 90 days of the date the expense was incurred</td><td>Not later than 45 days after receipt of the claims (may be extended an additional 60 days)</td></tr>
</table>

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

APPEALS PROCEDURES CHART					
	Where to File Appeals			**Filing Deadlines**	**Notification of Appeal Determination**
	Benefits Administered by Aetna	Dental Benefits	All Other Benefits		
Urgent Care Appeal[2]	<u>Medical</u> Aetna P.O. Box 14079 Lexington, KY 40512-4079 (888) 290-7241 Aetna P.O. Box 981106 El Paso, TX 79998-1106 (888) 290-7241 <u>Prescription Drug</u> Aetna Pharmacy Management P.O. Box 52444 Phoenix, AZ 85072-2444 (888) 290-7241	Delta Dental of Kansas, Inc. P.O. Box 49198 Wichita, KS 67201-9198 (800) 733-5823 or (800) 234-3375	Third-Party Administrator 529 S Anna Street Suite B Wichita, KS 67209 (316) 264-2339	Before expense is incurred	Not later than 72 hours after receipt of the appeal
Pre-Service Appeal[2]				Before expense is incurred	Not later than 30 days after receipt of the appeal
Post-Service Appeal				Within 180 days following receipt by you of an adverse benefit determin-ation	Not later than 60 days after receipt of the appeal
Disability Appeal				Within 180 days following receipt by you of an adverse benefit determin-ation	Not later than 45 days after receipt of the appeal (may be extended an additional 45 days)

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

CLAIMS AND APPEALS PROCEDURES

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

Claims for Benefits Administered by Aetna	Claims for Benefits Administered by Delta Dental	All Other Claims
Medical Benefits: Aetna P.O. Box 14079 Lexington, KY 40512-4079 Aetna P.O. Box 981106 El Paso, TX 79998-1106 *Prescription Drug Benefits:* Aetna Pharmacy Management P.O. Box 52444 Phoenix, AZ 85072-2444	Delta Dental of Kansas, Inc. P.O. Box 49198 Wichita, KS 67201-9198	Third-Party Administrator 529 S Anna Street Suite B Wichita, KS 67209

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

Claims for Benefits Administered by Aetna	Claims for Benefits Administered by Delta Dental	All Other Claims
(888) 290-7241	(800) 733-5823 or (800) 234-3375	(316) 264-2339

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

(a) The presentation of a prescription to a pharmacy to be filled at a cost to you determined by reference to a formula or schedule established in accordance with

the terms of the Plan and with respect to which the pharmacy exercises no discretion on behalf of the Plan;

(b) A request for prior approval of a benefit or service when the prior approval is not required under the terms of the Plan; or

(c) Interactions between you and Plan providers under arrangements by which the providers provide services or products at a predetermined cost to you and with respect to which the providers exercise no discretion on behalf of the Plan.

2. **Urgent Care Claims.** A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(a) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(b) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this subsection shall be made in accordance with the provisions of subsection 9 of this Part V. The Plan Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of the Plan's receipt of the

specified information, or the end of the period afforded the claimant to provide the specified additional information.

3. **Pre-Service Claims.** The term "pre-service claim" means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit in whole or in part on approval of the benefit in advance of obtaining medical care. In the case of a pre-service claim, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this subsection shall be made in accordance with subsection 10 of this Part V.

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

   (a) Is a communication by a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

   (b) Is a communication that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

5. **Concurrent Care Decisions.** If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, then any reduction or termination by the Plan of such course of treatment (other than by an amendment of the Plan or its termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan Administrator shall notify the claimant, in accordance with the provisions of subsection 9 of this Part V, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Moreover, any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking

into account the medical exigencies, and the Plan Administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in compliance with the provisions of subsection 10 of this Part V, and the appeal shall be governed by subsections 15, 16 or 17 of this Part V, as appropriate.

6. **Post-Service Claims.** The term "post-service claim" means any claim for a benefit under the Plan that is not a pre-service claim, as provided in subsection 3 of this Part V. In the case of a post-service claim, the Plan Administrator shall notify the claimant, in accordance with subsection 10 of this Part V, of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary, due to a failure of a claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

7. **Disability Claims.**

(a) In the case of a claim for disability benefits, the Plan Administrator shall notify the claimant, as provided in subsection 10 of this Part V, of the Plan Administrator's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Plan Administrator. This period may be extended by the Plan Administrator for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan Administrator, and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring an extension of time and the date by which the Plan Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan Administrator expects to render a decision. The notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent the decision on the claim, and the additional information needed to resolve those issues. The claimant will be afforded at least 45 days within which to provide the specified information.

(b) If the Plan Administrator does not strictly adhere to the Plan's claims and appeal procedures, the claimant will be "deemed" to have exhausted the Plan's internal claims and appeals process, regardless of whether the Plan Administrator asserts that it has "substantially complied" with those procedures, and the claimant will be able to initiate any available external review process or remedies available under ERISA or under state law, unless the violation was all of the following:

(i) De minimis (i.e., a minor violation);

(ii) Non-prejudicial (i.e., the violation does not cause, and is not likely to cause, harm or prejudice to the claimant);

(iii) Attributable to a good cause or matters beyond the Plan's control;

(iv) In the context of an ongoing good-faith exchange of information between the claimant and the Plan; and

(v) Not reflective of a pattern or practice of non-compliance by the Plan.

In addition, the claimant may request a written explanation of the Plan's basis for asserting that it meets this standard. The Plan must provide the explanation within 10 days of the claimant's request. If the court rejects the claimant's request for immediate review on the basis that the Plan met this standard, the Plan shall consider the claim as re-submitted upon the Plan receiving notice of such rejection and shall notify the claimant of the re-submission.

8. **Notification for Other Claims.** In the case of any other claim for benefits under the Plan, the Plan Administrator shall notify the claimant, as provided in subsection 10 of this Part V, of the Plan Administrator's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Plan Administrator. This period may be extended by the Plan Administrator for up to 90 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan, and notifies the claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring an extension of time and the date by which the Plan Administrator expects to render a decision.

9. **Calculating Time Periods for Claims.** For purposes of subsections 2 through 7 of this Part V, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the procedures set forth in subsection 1 of this Part V, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event a period of time is extended as permitted by subsections 3, 6, or 7 of this Part V due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

10. **Notification of the Decision.** The Plan Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by regulations issued by the Department of Labor under ERISA. The notification shall set forth in a manner calculated to be understood by the claimant:

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific Plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal;

(e) In the case of an adverse benefit determination,

(i) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request; or

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(f) In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;

(g) In the case of notification of an adverse determination for disability claims:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(1) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(2) The views of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(3) A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

(ii) If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(iii) Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; and

(iv) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits (whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to regulations issued under ERISA by the Department of Labor).

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

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

12. **Consistency.** The Trustees, the Plan Administrator, or both, shall conduct or have conducted on their behalf periodic reviews to verify that benefit claim determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan's provisions have been applied consistently with respect to similarly-situated claimants.

13. **Deciding the Appeal.** A claimant may appeal an adverse benefit determination with respect to a medical benefit administered by Aetna to Aetna. A claimant may appeal an adverse benefit determination with respect to a dental benefit to Delta Dental of Kansas, Inc. A claimant may appeal an adverse benefit determination with respect to all other benefits to the Trustees by mailing or delivering to the Plan Administrator, a written notice of appeal. The claimant may submit written comments, documents, records, or other information relating to the claim for benefits to the Plan Administrator. The Plan Administrator shall provide to the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record or other information is relevant to a claim for benefits shall be determined in accordance with standards issued by the Department of Labor.

In the case of a claim for disability benefits, before the Board of Trustees issues an adverse benefit determination on review, the Plan Administrator will provide the claimant, free of charge, with any new or additional evidence that is considered, relied upon, or generated by the Plan, insurer, or other person in connection with the claim. The Plan Administrator will provide this evidence as soon as possible and sufficiently in advance of the date by which the Plan is required to provide notice of the adverse benefit determination. In addition, before the Board of Trustees issues an adverse benefit determination based on a new or additional rationale, it will provide the claimant with such rationale as soon as possible so that the claimant will have reasonable opportunity to respond to such new evidence or rationale.

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

The Appellate Authority's decision shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Appellate Authority will not, however, consider a claimant's appeal unless the Appellate Authority receives it within 180 days following receipt by the claimant of a notification of an adverse benefit determination. The appeal will be considered by the Appellate Authority without deference to the original decision.

In deciding an appeal of any adverse benefit determination where the determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Appellate Authority shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Appellate Authority shall, when requested to do so by a claimant, identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. Any health care professional engaged for purposes of a consultation under this subsection shall be an

individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

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

14. **Appeal of Urgent Care Claims.** In the case of a claim involving urgent care:

(a) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(b) All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

15. **Notification of the Decision on Appeal; Urgent Care Claims.** In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant, in accordance with the provisions of subsection 20 of this Part V, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the Plan.

16. **Notification of the Decision on Appeal; Pre-Service Claims.** In the case of a pre-service claim that is not a claim involving urgent care, the Plan Administrator shall notify the claimant, in accordance with subsection 20 of this Part V, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. That notification shall be provided not later than 30 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.

17. **Notification of the Decision on Appeal; Post-Service Claims.** In the case of a post-service claim, the Plan Administrator shall notify the claimant, in accordance with subsection 20 of this Part V, of the Plan's benefit determination on review within a reasonable period of time. That notification shall be provided not later than 60 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination.

18. **Notification of the Decision on Appeal; Disability Claims.** In the case of a claim for disability benefits, the Plan Administrator shall notify the claimant, in accordance with subsection 20 of this Part V, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. That notification shall be provided not later than 45 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination. This period may be extended by the Plan Administrator for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan Administrator, and notifies the claimant, prior to the expiration of the initial 45-day period, of the

circumstances requiring an extension of time and the date by which the Plan Administrator expects to render a decision.

19. **Notification of the Decision on Appeal; Other Claims.** In the case of any other appeal for benefits under the Plan, the Plan Administrator shall notify the claimant, in accordance with subsection 20 of this Part V, of the Plan's benefit determination on review within a reasonable period of time. That notification shall be provided not later than 60 days after receipt by the Plan of the claimant's request for review of an adverse benefit determination. This period may be extended by the Plan Administrator for up to 60 days, provided that the Plan Administrator both determines that such an extension is necessary due to special circumstances, and notifies the claimant, prior to the expiration of the initial 60-day period, of the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render a decision.

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

    (a) The specific reason or reasons for the adverse determination;

    (b) Reference to the specific Plan provisions on which the benefit determination is based;

    (c) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits (whether a document, record or other information is relevant to a claim for benefit shall be determined by reference to regulations issued under ERISA by the Department of Labor);

    (d) A statement of the claimant's right to bring an action under Section 502(a) of ERISA; including, in the case of a disability claim, a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

    (e) In the case of an adverse benefit determination with respect to a claim involving health benefits:

        (i) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or similar criterion; or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;"

(f) In the case of notification of an adverse benefit determination for a disability claim:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(1) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(2) The views of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(3) A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration

(ii) If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

In the case of an adverse benefit determination on review, the Plan Administrator shall provide access to, and copies of, documents, records, and other information described in Paragraphs 20(c), (e)(i) and (e)(ii) and (f)(ii) and (iii) of this Part V, as is appropriate.

21. **Calculating Time Periods on Appeal.** For purposes of subsections 15, 16 and 17 of this Part V, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with subsection 13 of this Part V, without regard to whether all the information necessary to make a benefit determination

on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to subsections 18 or 19 of this Part V due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

22. **Extensions of Time.** A claimant may voluntarily agree to provide the Plan additional time within which to make a decision on a claim or an appeal.

23. **One-Year Limitation on Legal Action.** You or your representative may not bring any lawsuit against the Plan, or a representative or fiduciary of the Plan, more than one year from the later of: (i) the date your claim is first filed, or (ii) the date the Plan renders a decision on your claim or, if you timely file an appeal with the Plan, on your appeal. Refer to subsection 13 of this Part V for a statement of the requirement that you may not bring a lawsuit against the Plan unless you fully pursue your right to appeal under this Part V.

24. **Additional Claims and Appeals Procedures Under the No Surprises Act.** Under the No Surprises Act, an additional external review requirement applies to adverse benefit determinations that involve whether a group health plan is complying with the surprise billing and cost-sharing protections under the No Surprises Act.

Group health benefits offered under the Plan (other than benefits that are not subject to the No Surprises Act) will be subject to the following additional requirements:

(a) If you are appealing a denied claim, you will be able to review the claim file and present evidence and testimony as part of the appeals process. In considering your appeal, the Plan Administrator will provide you with any new or additional evidence that is considered, relied upon, or generated by the Plan in connection with your claim. The Plan Administrator will provide this evidence as soon as possible and sufficiently in advance of the date by which it is required to provide notice of the resolution of your appeal. In addition, before the Plan Administrator issues an adverse determination based on a new or additional rationale, it will provide you with such rationale as soon as possible so that you will have reasonable opportunity to respond to such new evidence or rationale.

(b) The Plan Administrator will take additional steps to ensure the independence and impartiality of the persons involved in deciding your claim or appeal.

(c) You will be entitled to continue coverage pending the outcome of an internal appeal. If you (or a dependent) are in an urgent care situation or are receiving an ongoing course of treatment, you will be allowed to proceed with expedited external review at the same time as the internal appeals process.

(d) Any notice of adverse benefit determination will include the following additional content:

(i) Information sufficient to identify the claim involved, including the date of the service, the health care provider, and the claim amount (if applicable);

(ii) A description of the Plan's standard, if any, that was used in denying the claim;

(iii) A statement that you may receive, upon request and free of charge, reasonable access to all diagnosis and treatment codes (and their meanings) relevant to the claim, including the right to copies of those diagnosis and treatment codes;

(iv) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

(v) Information regarding the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.

(e) If the Plan Administrator does not strictly adhere to the Plan's claims and appeal procedures, you will be "deemed" to have exhausted the Plan's internal claims and appeals process, regardless of whether the Plan Administrator asserts that it has "substantially complied" with those procedures, and you will be able to initiate any available external review process or remedies available under ERISA or under state law, unless the violation was all of the following:

(i) De minimis (i.e., a minor violation);

(ii) Non-prejudicial (i.e., the violation does not cause you, and is not likely to cause you, harm or prejudice);

(iii) Attributable to a good cause or matters beyond the Plan's control;

(iv) In the context of an ongoing good-faith exchange of information between you and the Plan; and

(v) Not reflective of a pattern or practice of non-compliance.

In addition, you are entitled, upon written request, to an explanation of the Plan's basis for asserting that it meets this standard. If the external reviewer or the court rejects your request for immediate review on the basis that the Plan met this standard, you have the right to resubmit and pursue the internal appeal of the claim.

(f) There will be an opportunity for review of the claimant's denied appeal by a party outside the Plan (or the plan sponsor or insurer), as described below, but only with respect to claims that are subject to the surprise billing protections set forth in Sections 716 and 717 of ERISA, as added by the No Surprises Act, or if the claimant

disputes the Plan's determination regarding whether the claim is subject to the surprise billing protections of the No Surprises Act:

(i) The claimant, or the claimant's authorized representative, may request an external review of a denied Claim by making a written request to the Plan Administrator (or its designee) within four months of receipt of notification of the final internal denial of benefits. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. The Plan Administrator (or its designee) may charge a filing fee to the claimant requesting an external review, subject to applicable laws and regulations.

(ii) Within five business days of receipt of the request, the Plan Administrator (or its designee) will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal denial relates to payment of a claim under the surprise billing protections set forth in Sections 716 and 717 of ERISA, as added by the No Surprises Act, or the claimant disputes the Plan's determination regarding whether the claims is subject to the No Surprises Act.

(iii) The Plan Administrator (or its designee) shall provide the claimant (or authorized representative) with a written notice of the decision as to whether the Claim is eligible for external review within one business day after completion of the preliminary review. The Notice of Final External Review shall include the following:

(1) The reason for ineligibility and the availability of the Employee Benefits Security Administration at 866-444-3272, if the request is complete but not eligible for external review;

(2) If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the claimant to perfect the external review request by the later of the following:

(a) the four-month filing period; or

(b) within the 48-hour time period following the claimant's receipt of notification.

(iv) An Independent Review Organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC) or a similar nationally recognized accrediting organization shall be assigned to conduct the external review. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review.

(v) The assigned IRO shall provide the Plan Administrator (or its designee) and the claimant with a written notice of the final external review decision within 45 days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the claimant, the Plan, and the Plan Administrator, except to the extent that other remedies may be available under state or federal law.

(vi) The Plan Administrator (or its designee) shall provide the claimant the right to request an expedited external review upon the claimant's receipt of either of the following:

(1) A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the claimant or the claimant's ability to regain maximum function and the claimant has filed an internal appeal request; or

(2) A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the claimant or the claimant's ability to regain maximum function or if the final determination involves any of the following:

(a) an admission,

(b) availability of care,

(c) continued stay, or

(d) a health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

(vii) Immediately upon receipt of the request for expedited external review, the Plan Administrator (or its designee) will do both of the following:

(1) Perform a preliminary review to determine whether the request is eligible for an external appeal review; and

(2) Send a notice of the Plan's decision.

(viii) Upon determination that a request is eligible for external review, the Plan Administrator (or its designee) will do both of the following:

(1) Assign an IRO; and

(2) Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

(ix) The assigned IRO will provide notice of final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after receipt of the expedited external review request. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the Plan Administrator (or its designee) and the claimant written confirmation of its decision within 48 hours after the date of providing that notice.

Plumbing and Pipefitting Industry Health and Welfare Fund of Kansas

529 S Anna St, Suite B • Wichita, KS 67209
Phone: (316) 264-2339 • Email: ua441@bmgiweb.com

June 2024

Re: Changes to the Health & Welfare Plan

Dear Participant:

This Participant Notice will advise you of certain material modifications that have been made to the Plumbing and Pipefitting Industry Health and Welfare Plan of Kansas. This information is important to you and your dependents. Please review this summary carefully, and keep it with your copies of the Plan's Summary Plan Description and Summary of Benefits and Coverage.

Vision Benefits

We revised the Plan's vision benefit effective for claims incurred on and after June 1, 2024, to pay up to $600 per participant every two calendar years for vision care expenses (including routine eye examinations covered under the Plan's medical benefit), and up to $400 per employee each calendar year for expenses the employee incurs for prescription safety glasses (lenses and frames) or contact lenses. We also enhanced the medical benefits administered by Aetna to cover the cost of routine eye examinations performed by a network provider at 100%.

Weekly Disability Benefits

We increased the amount of the non-occupational weekly disability benefit from $300 to $600 (or 66⅔% of weekly compensation, if less). This change is effective with respect to non-occupational disabilities occurring on or after June 1, 2024.

Routine Cancer Screenings

We revised the Plan to provide that charges for the following routine cancer screenings incurred on or after June 1, 2024, are covered at 100% if provided by an in-network provider: colonoscopies, digital rectal examinations, mammograms, Pap smears, and prostate specific antigen tests.

Retiree Benefit Program

We expanded the Plan's Retiree Benefit Program effective June 1, 2024, to provide that when a retiree's coverage under the Retiree Benefit Program ends, the spouse of the retiree will continue to be eligible for coverage under the Retiree Benefit Program until the first day of the month in which the spouse attains age 65 or otherwise becomes ineligible.

Retiree Benefit Program Premiums

We have moved the starting date of the 12-month stability period for purposes of setting the premiums for the Plan's Retiree Benefit Program from March 1 to June 1, effective as of June 1, 2024. The premiums for the Retiree Benefit Program will not change for the period from June 1, 2024, through May 31, 2025. The premium for Single Coverage will remain at $300 per month. The premium for Family Coverage will remain at $600 per month.

COBRA Rates

We have moved the starting date of the 12-month stability period for purposes of setting the Plan's COBRA rates from March 1 to June 1, effective as of June 1, 2024. The COBRA rates will not change for the period from June 1, 2024, through May 31, 2025. The rate for Single Coverage will remain at $600 per month. The rate for Family Coverage will remain at $1,200 per month.

If you have any questions about this summary, please contact the Plan Administrator.

Sincerely,

THE TRUSTEES