

Summary Plan Description

Health and Welfare Benefits



SAMPLE **Preferred Provider Organization (PPO)**

This document is a representative sample of the Summary Plan Description issued by the Steelworkers Health and Welfare Fund to Fund Participants.

This is not a legally binding document. An actual Summary Plan Description (SPD) will include Schedules of Benefits specific to each participating employer.

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SECTION I: GENERAL INFORMATION

INTRODUCTION

This booklet, along with the accompanying letter from the Fund identifying the particular benefits available to your group and other special rules, describes the benefits that are available to you as a Participant in the Steelworkers Health and Welfare Fund (the “Fund”), and the conditions under which the benefits are available. Please read this booklet carefully so you will understand your coverage. If you have questions about this booklet, or any other questions about the Fund (other than questions about a specific benefit or a specific claim), please contact the Steelworkers Health and Welfare Fund Administrative Office, Five Gateway Center, Suite 620, Pittsburgh, Pennsylvania 15222-1219 (“Fund Office”). You may also call the Fund Office toll-free at 1-888-296-7493 for assistance. Office hours are 8:00 AM to 5:00 PM Eastern Time, Monday through Friday. At other times, you may leave a message and your call will be returned as soon as possible. If you have questions about a particular benefit or an outstanding claim, you should contact the benefit provider directly at the toll-free number listed on your identification card.

This booklet is intended only to provide a summary of your benefits. The terms and conditions of the benefits available from the Fund are more fully discussed in the document called the *Steelworkers Health and Welfare Plan* (the “Plan”). Please contact the Fund Office if you would like a copy of the Plan. If there are any contradictions between this booklet and the Plan, the terms of the Plan will govern.

The Fund was established in 1944. Its purpose is to provide health and other benefits to individuals employed under a collective bargaining agreement between the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (“USW”) (the “Union”) or other participating union and a participating Employer. The Fund is managed by a Board of Trustees.

All contributions to the Fund are made by the Employers (or covered individuals) in accordance with the provisions of a collective bargaining agreement (or other written agreement with the Fund) that require periodic contributions to the Fund.

The Fund Office will provide you, upon written request, with information as to whether a particular Employer is contributing to this Fund on behalf of Employees working under collective bargaining agreements and, at reasonable cost, a copy of any collective bargaining agreement authorizing contributions to the Fund. A complete list of the employers contributing to the Fund may be obtained upon written request to the Fund Office.

Benefits are provided from the Fund’s assets, which are held in trust (along with their earnings) for the purpose of providing benefits to covered individuals and defraying reasonable administrative expenses. Benefits may be paid either directly by the Fund from the trust assets or by an entity with whom the Fund has a contract to provide benefits, such as an insurance carrier.

What benefits are available from the Fund?

The Fund provides the following benefits:

- Medical Benefits
- Prescription Drug Benefits
- Dental Benefits
- Vision Benefits
- Death Benefits
- Accidental Death and Dismemberment Benefits
- Short Term Disability Benefits

Not all Participants are eligible for all of the benefits offered. The Fund Letter accompanying this booklet lists the benefits for which you are or may become eligible.

Whom do I contact with questions about benefits?

The identification card that you receive for Medical (including Prescription Drug), Dental and/or Vision Benefits includes a toll-free phone number and an address for questions about that benefit, including whether a particular service is covered, and questions about the status of your claim. You should contact the Fund Office or the insurance company for questions about Death, Accidental Death and Dismemberment and Short Term Disability Benefits and claims. For general questions about the Fund, or if you are having problems getting a satisfactory answer to your questions about a benefit, please contact the Fund Office.

KEY TERMS

The meaning of some of the terms used most frequently throughout this booklet is explained below:

Benefit

A Benefit is one of the benefits offered by the Fund. The benefits for which you are or may become eligible are listed in the Fund Letter accompanying this booklet.

Board of Trustees

The Board of Trustees is the group of individuals appointed to manage the operation and administration of the Fund.

Claims Administrator

The Claims Administrator is the entity responsible for claims processing and payment.

Dependent

Dependents include the following persons:

- your spouse;
- each of your unmarried children who is under age 19;
- each of your unmarried children who is age 19 or older but younger than age 25, enrolled and recorded as a full-time student at an accredited high school, college, university or vocation training school, and resides with or is wholly dependent on you for financial support; and
- each of your unmarried children who is age 19 or older and incapable of self-support as the result of physical or mental incapacity that existed before he or she reached age 19, and who is wholly dependent upon you for support.

The term “children” includes any stepchild, legally adopted child or child placed for adoption with you, and a child for whom you have been appointed legal guardian.

Employee

An Employee is an employee or former employee of an Employer who works or worked in a job classification covered by a collective bargaining agreement requiring contributions to be made to the Fund, or who works in a position set forth in some other written agreement accepted by the Board of Trustees.

Employer

An Employer is an employer that is or was a party to a collective bargaining agreement, or other written agreement accepted by the Board of Trustees, that requires contributions to be made to the Fund on behalf of its Employees.

ERISA

ERISA is the Employee Retirement Income Security Act of 1974, as amended, a federal law that governs the operation of the Fund.

Fund

The Fund is the Steelworkers Health and Welfare Fund.

Fund Letter

The Fund Letter is the letter from the Fund that accompanies this booklet and that identifies the particular benefits available to your group and other special rules for your group that are not reflected in this more general booklet.

Fund Office

The Fund Office is the Steelworkers Health and Welfare Fund Administrative Office, Five Gateway Center, Suite 620, Pittsburgh, Pennsylvania 15222-1219. The Board of Trustees has delegated the day-to-day administrative duties to persons who work in the Fund Office.

Group Insurance Policy

The Group Insurance Policy is the insurance policy that the Fund has purchased from an insurance company to pay a particular Benefit. If a benefit booklet describing a particular Benefit refers to the Group Insurance Policy for that Benefit and you would like to review that Group Insurance Policy, please contact the Fund Office.

Participant

A Participant is an Employee who has met the requirements to be eligible for benefits from the Fund, and has not lost eligibility for those benefits.

Participation Agreement

A Participation Agreement is an agreement implementing the terms and conditions of a collective bargaining agreement requiring contributions to the Fund on behalf of Employees.

Plan

The Plan is the Steelworkers Health and Welfare Plan, which is a written document describing the operation of the Fund.

Plan Administrator

The Plan Administrator is the Board of Trustees of the Steelworkers Health and Welfare Fund.

Qualifying event

A qualifying event is an event that entitles you to elect COBRA continuation health coverage from the Fund.

Union

The Union is the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (“USW”), or any successor thereto.

You

The terms “you” and “your” generally refer to Participants. In the section entitled Eligibility for Benefits, “you” and “your” include both Participants and Employees who are not yet Participants. In the section entitled Claims and Review Procedures the term “you” means all persons with a claim or potential claim for benefits. Also, in the section(s) describing the available benefits, the terms “you” and “your” include both Participants and Dependents.

FUND MANAGEMENT

Who manages the Fund?

The Fund is managed by the Board of Trustees, which meets periodically to review and decide Fund matters. The Board of Trustees may engage other persons or entities, such as those employed at the Fund Office, to conduct the day-to-day operations of the Fund. The Board of Trustees may also delegate certain of its duties to other persons or entities, as the Board considers advisable.

The Board (or, where applicable, the Board’s delegate) has the exclusive authority, in its sole and absolute discretion, to:

- take all actions necessary to manage the Fund;
- administer and interpret the Plan and all other documents maintained in connection with the Plan; and
- decide all matters arising in connection with the operation or administration of the Plan.

The Board fully intends to continue to maintain the Plan indefinitely. However, the Board has the sole and absolute discretion to modify or terminate the Plan at any time.

What does the Fund Office do?

The Fund Office handles the day-to-day administrative functions for the Fund, including distributing this booklet and other information to you and your Dependents, responding to your requests about the Fund, and maintaining appropriate participant and employer information. You may contact the Fund Office with any questions that you have at the address or phone number set forth in the Introduction.

What role do Insurance Companies and other providers play?

In some cases, the Board of Trustees has contracted with an insurance company for the purchase of an insurance policy to pay benefits, or with an insurance company or other entity for the provision of administrative services for a particular benefit (such as to process claims). This booklet discusses the role that an insurance company or other entity plays, if any, with respect to a particular benefit. Because of these arrangements, if you contact the Fund Office with questions about a particular benefit, the Fund Office may in some cases refer you to an insurance carrier or other entity for an answer.

You should keep in mind that, even though a claim may initially be processed by an insurance company or other entity, the Board of Trustees is ultimately responsible for paying benefits. It is for this reason that, as explained in the Claims and Review Procedures section, the Board of Trustees has the final authority to grant or deny a claim.

The benefits described in this Summary Plan Description (SPD) are guaranteed under a contract of insurance issued to the Fund by the following insurance companies, each of which provides claims payment and other administrative services to the Fund.

<u>Benefit</u>	<u>Claims Administrator</u>
Medical, Prescription Drug, Vision	Highmark Blue Cross Blue Shield Fifth Avenue Place 120 Fifth Avenue Pittsburgh, PA 15222
Dental	United Concordia Companies, Inc. 100 Senate Avenue Senate Plaza Camp Hill, PA 17011
Death, Accidental Death & Dismemberment, Short Term Disability	Fort Dearborn Life Insurance Company Emerald Corporate Park 20445 Emerald Parkway, Suite 400 Cleveland, OH 44135

Detailed information concerning the claims and appeals procedures of each insurance company is included in the applicable benefits section of this SPD.

ELIGIBILITY FOR BENEFITS

How do I become eligible for benefits from the Fund?

You will become a Participant in the Fund on the first day for which the required contributions to the Fund are made on your behalf for one or more benefits. That date is specified in the Fund Letter.

Once you become a Participant, you will generally be eligible to receive all of the benefits set forth in this booklet and in the Fund Letter. This booklet may also contain additional eligibility requirements for a particular benefit, such as completing an enrollment form, so you should read this booklet carefully.

If you choose not to become a Participant on the earliest possible date, or, if you elect to terminate your participation in a Fund benefit plan but you otherwise remain eligible, you may become a Participant on any of the following dates, so long as the required contributions are made to the Fund on your behalf:

- a date permitted under the annual open enrollment period applicable to your Employer, if any. (the Fund Letter describes any applicable annual open enrollment period);
- the next rate renewal date as agreed to in the Participation Agreement;
- if you are or were covered under another group health plan, a date that is no later than thirty (30) days after (a) you lose coverage under that plan due to divorce, legal separation, or a termination or reduction in your hours of employment; or (b) Employer contributions to that plan stop, but only if you notify the Fund Office within thirty (30) days of losing coverage or of the termination of Employer contributions; or
- if you acquire a new Dependent (including a new spouse), a date that is no later than thirty (30) days from the date on which you acquire the Dependent, so long as you notify the Fund Office within thirty (30) days of acquiring the Dependent.

How do my spouse and other Dependents become eligible for benefits from the Fund?

Your Dependents (including your spouse) will become eligible for benefits on the day that you become a Participant (so long as the required contributions are made to the Fund on their behalf). This booklet may contain additional eligibility requirements for a particular benefit, such as completing an enrollment form, so you should read this booklet carefully.

If you choose not to enroll your Dependents on the earliest possible date, or if you elect to terminate their participation in a Fund benefit plan but they otherwise remain eligible, any Dependent may be enrolled on any of the following dates, so long as the required contributions are made to the Fund on his or her behalf:

- a date permitted under the annual open enrollment period applicable to your Employer, if any (the Fund Letter describes any applicable open enrollment period);
- the next rate renewal date as agreed to in the Participation Agreement; or
- if your Dependent is or was covered under another group health plan, a date that is no later than thirty (30) days after (a) he or she loses coverage under that plan due to divorce, legal separation, or a termination or reduction in hours of employment; or, (b) Employer contributions to that plan stop, but only if you or your Dependent notifies the Fund Office within thirty (30) days of losing coverage or of the termination of Employer contributions.

How do I lose eligibility for benefits?

You will be a Participant until the earliest of the following events occurs (unless the Fund Letter contains different rules, in which case those rules will apply):

- you cease employment with an Employer;
- your Employer is no longer required to make contributions for you, in which case you will continue to be a Participant through the last day of the month for which your Employer is required to make contributions for you;
- the Fund does not receive contributions required to be made for your coverage for any particular month, in which case you will cease to be a Participant as of the last day of the previous month; or
- the date on which the Plan terminates.

Once you stop being a Participant, you will no longer be eligible to receive any benefits, except to the extent that COBRA coverage (discussed below) applies to you. In addition, in limited circumstances, benefits may be continued to the extent provided in the applicable insurance contract.

How do my spouse and other Dependents lose their eligibility for benefits?

Each of your Dependents (including your spouse) will continue to be eligible for benefits until one of the following events occurs (unless the Fund Letter contains different rules, in which case those rules will apply):

- he or she no longer meets the definition of Dependent set forth above;
- the Fund does not receive contributions required to be made for a Dependent's coverage for any particular month, in which case he or she will cease to be eligible for benefits as of the last day of the previous month; or
- the date on which you stop being a Participant, except to the extent that COBRA coverage applies.

How do payroll deductions affect my coverage?

If your Employer requires you to contribute towards your coverage through payroll deductions and you make a change in coverage or enrollment for yourself or your Dependents, you may need to change the amount you have authorized your Employer to deduct from your pay. If you do not do so, your Employer may not make the appropriate contributions to the Fund on behalf of you and/or your Dependents, resulting in termination of your benefits. Check with your Employer for details.

What if I go on leave for family or medical reasons?

The Family and Medical Leave Act (FMLA) is a federal law that permits eligible Employees to take up to twelve (12) weeks of unpaid, job-protected leave each year from their Employer for certain specified reasons. If you qualify, you may take FMLA leave for any of the following reasons:

- the birth of your child and to care for that child;
- the placement of a child with you for adoption or foster care;
- to care for your spouse, child or parent with a serious health condition; or
- a serious health condition that makes you unable to perform your job.

During your FMLA leave, your Employer must provide you with the same health benefits that you were receiving immediately before your leave. This means that your Employer must continue to make the same contributions to the Fund on your behalf during your FMLA leave that it was making while you were at work.

Contact your Employer for further information and instructions on how to apply for FMLA leave.

What if I have military service?

If you leave employment with your Employer for certain types of military training or service, and return to your Employer within ninety (90) days, your Employer may be required under federal law to begin to contribute to the Fund on your behalf immediately upon your return, in which case you would not have to satisfy any waiting period. Contact your Employer for details.

What if I terminate employment and my new Employer's plan doesn't cover pre-existing conditions?

The Fund does not limit medical coverage for pre-existing conditions, but some plans do. Most plans are required to reduce this limit if you had prior coverage. For this reason, when you lose eligibility for medical benefits, the Fund is required to provide you with a Certificate of Coverage showing the amount of time that you were continuously covered by the Fund. If you are eligible for and elect COBRA coverage as described elsewhere in this booklet, you will receive another Certificate of Coverage after your COBRA coverage expires. You may also request a Certificate of Coverage at any time while you are still covered by the Fund or during the twenty-four (24) months after you lose your eligibility for medical benefits.

EXTENDED COVERAGE

How can I continue coverage once I am no longer eligible for benefits?

Once you are no longer eligible for medical benefits, you may be able to continue coverage in two ways: by electing COBRA coverage as described below or, if your benefits are insured by a company that provides conversion rights, by purchasing an individual insurance policy. (If such a provision is offered, it will be described later in this booklet.)

What is COBRA coverage?

COBRA continuation coverage is a continuation of the group health coverage available to you and your covered Dependents from the Fund when coverage would otherwise end because of a life event known as a “qualifying event”. Specific qualifying events are listed below.

Individuals who elect COBRA continuation coverage must pay for COBRA continuation coverage. The administration of COBRA coverage is the responsibility of the Fund Office.

In order to protect your and your family’s rights, it is important to keep the Fund Office informed of the current addresses of all of your family members who are or could become eligible for COBRA coverage. You should also keep a copy, for your records, of any notices you send to the Fund Office.

Which of my family members are eligible for COBRA coverage?

Each of your Dependents who is covered from the Fund when a qualifying event as defined below occurs is eligible for COBRA coverage unless he or she is entitled to Medicare. In addition, if a child is born to or adopted by you while your COBRA coverage is in effect, that child is eligible for COBRA coverage. You and each of your Dependents eligible for COBRA coverage is referred to as a “qualified beneficiary”.

What events are qualifying events that make me and my Dependents eligible for COBRA coverage?

You and your eligible Dependents will each become a qualified beneficiary and may independently elect COBRA coverage when a qualifying event occurs. A qualifying event may be different for you and your eligible Dependents.

Qualifying Events for You

The following events are qualifying events for you if they result in a loss of coverage, unless you are entitled to Medicare:

- reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct);
- you are a retiree of an Employer contributing to the Fund on behalf of its retired employees and your former Employer commences federal bankruptcy proceedings under title 11 of the U.S. Code.

Qualifying Events for Your Dependents

The following are qualifying events for your Dependents if they result in a loss of coverage:

- your death;
- reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct);
- your divorce or legal separation;
- you are a retiree of an Employer contributing to the Fund on behalf of its retired employees and your former Employer commences federal bankruptcy proceedings under title 11 of the U.S. Code;
- your becoming enrolled in Medicare (Part A, Part B, or both); or
- for a child, ceasing to qualify as a Dependent.

Employer Withdrawals from the Fund

If you or one of your Dependents has a qualifying event and your Employer withdraws from the Fund or ceases to be a participating Employer due to non-payment of contributions, you and your Dependents will be eligible for COBRA coverage until your Employer makes group health coverage available to (or starts contributing to another multiemployer plan with respect to) a class of employees formerly covered from the Fund, at which point the other plan will be required to assume the COBRA obligation with respect to you and your Dependents.

If a qualifying event occurs, how do my Dependents and I get COBRA coverage?

NOTE: If your Fund Letter provides that your Employer has elected to retain responsibility for the administration of COBRA coverage, this section does not apply and you will need to contact your Employer for details on how to obtain COBRA coverage

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is termination of employment or reduction in your hours of employment, your death, commencement of a proceeding in bankruptcy with respect to the Employer, or your becoming enrolled in Medicare (Part A, Part B or both), the Employer must notify the Fund of the qualifying event within thirty (30) days of the qualifying event.

For the other qualifying events (your divorce or legal separation, or your child losing eligibility for coverage as a Dependent), you or your Dependent(s) must notify the Fund Office within sixty (60) days of the qualifying event.

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Fund coverage would otherwise have been lost.

Is there a special rule if I am eligible for Trade Adjustment Assistance benefits?

Each qualified beneficiary is entitled to a second COBRA election period if: (a) you are certified by the Department of Labor as eligible for trade act assistance (TAA) benefits under the Trade Act of 1974 on or after November 4, 2002; (b) the qualified beneficiary lost coverage under the Fund due to your job loss that resulted in eligibility for TAA benefits; and (c) the qualified beneficiary did not elect COBRA coverage during the initial election period resulting from that job loss. Specifically, each qualified beneficiary has another opportunity to elect COBRA during the sixty (60) day period that begins on the first day of the month in which you were certified, and the election must also be made within six months after the date Fund coverage is lost. You or your Dependent(s) are responsible for notifying the Fund Office of your TAA eligibility and providing a copy of the certification. Accordingly, if you are eligible for TAA benefits, you or your Dependent(s) must contact the Fund Office immediately after you become certified or all qualified beneficiaries will lose the special COBRA rights. If a qualified beneficiary elects COBRA coverage under this provision, it will begin on the first day of the sixty (60) day election period and will last the same length of time as if an election had been made based on the original qualifying event.

How long will my COBRA coverage last?

COBRA continuation coverage is a temporary continuation of coverage. Unless there is an early cut-off as described below, COBRA continuation coverage lasts for up to eighteen (18) months if the qualifying event is the termination of or reduction in hours of your employment, or up to thirty-six (36) months if the qualifying event is your death, your divorce or legal separation, your becoming enrolled in Medicare (Part A, Part B or

both), or a child losing eligibility as a Dependent. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability Extension of Eighteen (18) Month Period of Continuation Coverage

If you or any covered Dependent are determined by the Social Security Administration to be disabled at some time before the 60th day of COBRA continuation coverage, you and each of your covered Dependents can receive up to an additional eleven (11) months of COBRA coverage, for a total maximum of twenty-nine (29) months. You must make sure that the Fund Office is notified of the Social Security Administration's determination within sixty (60) days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage to be eligible for the additional eleven (11) months of COBRA continuation coverage.

Second Qualifying Event Extension of Eighteen (18) Month Period of Continuation Coverage

If you or a covered Dependent has another qualifying event while receiving COBRA continuation coverage, your covered Dependents can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to your spouse and dependent children if you die, become enrolled in Medicare (Part A, Part B or both), or get divorced or legally separated. The extension is also available to a child when that child stops being eligible under the Fund as a Dependent. In all of these cases, you must make sure that the Fund Office is notified of the second qualifying event within sixty (60) days of the second qualifying event and within the initial eighteen (18) months of continuation coverage.

What will cause an early cut-off of COBRA coverage?

COBRA coverage will automatically end as of the date any of the following cut-off events occurs:

- the covered individual does not pay the premium for COBRA coverage on time;
- the covered individual becomes covered under any other group health plan that does not limit coverage for his or her pre-existing conditions;
- the covered individual becomes enrolled in Medicare (Part A, Part B or both);
- your Employer withdraws from the Fund and makes other group health coverage available to (or starts contributing to another multiemployer plan with respect to) a class of employees formerly covered from the Fund; or
- for a covered individual who is receiving COBRA coverage based on a determination of disability, the first day of the month immediately following the month in which there is a final determination by the Social Security Administration that the individual is no longer disabled.

The covered individual is required to notify the Fund Office of any of the above cut-off events and the Fund may terminate COBRA coverage retroactively to the date of the cut-off event.

How can I get additional information about COBRA?

If you have questions about your COBRA continuation rights and coverage, you should contact the Fund Office or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

What if a court orders the Fund to cover my children?

The Fund will comply with the terms of any judgment, decree or order that creates or recognizes the right of one or more of your children to receive medical benefits, so long as that judgement, decree or order is a Qualified Medical Child Support Order (QMSCO) under Section 609 of ERISA. Coverage under such an order

will not extend the maximum period of COBRA coverage. A description of the procedures governing QMSCOs may be obtained, without charge, from the Fund Office.

CLAIM AND REVIEW PROCEDURES

How do I file a claim for benefits?

Each benefit section of this booklet sets forth a procedure for filing claims for that particular benefit with the appropriate Claims Administrator and a time limit within which your claims must be filed. The Plan document contains a general explanation of the claims procedures, including the items to be taken into account by the Claims Administrator (or Board of Trustees) and the required elements of the notification of denial of your claim or appeal. Contact the Fund Office for details.

When will I be notified of the Claims Administrator's decision on my claim?

You will be notified of the Claims Administrator's decision on your claim no later than the following date:

- **Urgent Care Claims**

In the case of an Urgent Care Claim, you will be notified of the Claims Administrator's decision within seventy-two (72) hours after its receipt of the claim. An Urgent Care Claim is a claim for medical care or treatment where your life or health or ability to function properly would be seriously jeopardized by applying the longer time periods set forth below. If you do not provide enough information for the Claims Administrator to determine the benefits that are due, the Claims Administrator will notify you of the specific information necessary to complete the claim within twenty-four (24) hours after it receives the claim. You will then have a reasonable amount of time (at least forty-eight (48) hours) to provide the requested information, and the Claims Administrator will notify you of its decision within forty-eight (48) hours after it receives the information. If your claim is to extend the course of treatment beyond the period of time or number of treatments approved by the Claims Administrator and you make your claim at least twenty-four (24) hours before the period of time or number of treatments ends, you will be notified of the Claims Administrator's decision on your claim within twenty-four (24) hours of the Claims Administrator's receipt of the claim.

- **Concurrent Care Decisions**

In the case of a claim involving an ongoing course of treatment, you will be notified of the Claims Administrator's decision in enough time before any reduction or termination of the treatment to permit you to file an appeal and obtain a decision on appeal before the benefit is reduced or terminated. (This rule does not apply to reductions or terminations of benefits as a result of an amendment or termination of the Plan.)

- **Pre-Service Claims**

In the case of any other claim that must be approved in advance of obtaining the service or care, you will be notified of the Claims Administrator's decision within fifteen (15) days of its receipt of the claim or thirty (30) days if the Claims Administrator determines that an extension is necessary due to matters beyond its control, in which case it will notify you within the fifteen (15) day period of why the extension is required, when a decision is expected to be made, and any additional information that it needs to decide the claim. You will then have forty-five (45) days to provide that information.

- **Other Claims**

In the case of all other claims (except for claims for Death Benefits and Accidental Death and Dismemberment Benefits, which are discussed below), you will be notified of the Claims Administrator's decision within thirty (30) days of its receipt of the claim or forty-five (45) days if the Claims Administrator determines that an extension is necessary due to matters beyond its control, in which case it

will notify you within the thirty (30) day period of why the extension is required, when a decision is expected to be made, and any additional information that it needs to decide the claim. You will then have forty-five (45) days to provide that information.

- Claims for Death Benefits or Accidental Death and Dismemberment Benefits
In the case of a claim for Death Benefits and Accidental Death and Dismemberment Benefits, you will be notified of the Claims Administrator's decision within ninety (90) days of its receipt of the claim or one hundred eighty (180) days if the Claims Administrator determines that an extension is necessary due to matters beyond its control, in which case it will notify you within the ninety (90) day period of why the extension is required and when a decision is expected to be made.

If my claim is denied, how do I appeal?

If you file a claim for benefits in accordance with the applicable benefit provisions and the Claims Administrator either denies the claim or fails to respond to you by the deadline set forth above, you may file a written appeal with the Claims Administrator within one hundred eighty (180) days of the date you were notified that the claim was denied or one hundred twenty (120) days in the case of a claim for Death Benefits or Accidental Death and Dismemberment Benefits. In support of your appeal, you may submit written comments, documents, and other information relating to your claim, and the Claims Administrator will provide you with reasonable access to, and copies of, all documents, records or other information relevant to your claim upon your request. In the case of an Urgent Care Claim (as defined above), you may request an expedited review process. If you request an expedited review process, you may submit your request for appeal orally or in writing and all information necessary to the appeal will be transmitted between the Claims Administrator and you by telephone, fax, or other similarly expeditious method.

When will the Claims Administrator notify me of its decision on my appeal?

The Claims Administrator will notify you of its decision on your appeal by the following date:

- Urgent Care Claims
In the case of urgent Care Claims, the Claims Administrator will notify you of its decision within seventy-two (72) hours after its receipt of the appeal.
- Pre-Service Claims; Concurrent Care Decisions
In the case of Pre-Service Claims and Concurrent Care Decisions (as described above), the Claims Administrator will notify you of its decision within thirty (30) days of its receipt of the appeal.
- Disability and Post-Service Claims
In the case of Disability and Post-Service claims, the Claims Administrator will notify you of its decision on the appeal within a reasonable period of time, but no later than forty-five (45) days (in the case of a Disability Claim) or sixty (60) days (in the case of a Post-Service Claim) after receipt of the appeal. If the Claims Administrator provides for two levels of appeals, a thirty (30) day period will apply instead of the forty-five (45) and sixty (60) day periods.
- Other Claims
In the case of all other claims, the Claims Administrator will notify you of its decision on the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal, which may be extended up to an additional sixty (60) days if special circumstances require an extension of time for processing the claim, in which case the Claims Administrator will notify you of the extension (along with a description of the special circumstances and the date by which it expects to render a decision).

What if the Claims Administrator denies my appeal?

If your appeal is denied by the Claims Administrator, you may file another appeal with the Board of Trustees within one hundred twenty (120) days of the date you were notified that your appeal was denied. In support of your appeal, you may submit written comments, documents, records and other information relating to the claim. In reviewing the appeal, the Board of Trustees will take into account only materials and information you submitted to the Claims Administrator, or that was considered in connection with the initial claim or a prior appeal. The decision of the Board of Trustees will be in writing and will be final and binding on all parties, subject to your rights under ERISA.

SECTION II: MEDICAL BENEFITS

PLAN OVERVIEW

Your Employer has entered into an agreement with the Steelworkers Health and Welfare Fund to provide a managed health care plan administered by Highmark Blue Cross Blue Shield (Highmark). The plan, which is called the ***Blue Cross and Blue Shield PPO***, is a Preferred Provider Organization (PPO) that allows you to choose between two levels of health care: **In-network** or **Out-of-network**. In-network care is care you receive from providers in the Blue Cross and Blue Shield PPO network. Out-of-network care is care you receive from providers who are not in the Blue Cross and Blue Shield PPO network.

Note: All inpatient hospital care and inpatient mental health/substance abuse care must be precertified to assure it is covered. For more information, refer to the HealthCare Management Services section of this benefit booklet.

HOW TO FIND A NETWORK PROVIDER

The Blue Cross and Blue Shield PPO network includes physicians, specialists, hospitals and other health care providers. To locate a network provider near you, or to learn whether your current physician is in the network, refer to your separate provider directory or go online to www.highmarkbcbs.com for more information. Additional copies of the provider directory may be obtained, without charge, by contacting Member Services at the toll-free number on your identification card. In order to maximize the benefits of your plan, you should check to see that your provider is in the network before you receive care.

KEY TERMS

Allowable Charge

The dollar amount the Claims Administrator has determined is reasonable for covered services provided under your plan. The Allowable Charge is also referred to as “usual, customary and reasonable” fee.

Claim

A request for preauthorization or prior approval of a covered service or for the payment or reimbursement of the charges or costs associated with a covered service. Claim includes:

- **Pre-service Claim** – A request for preauthorization or prior approval of a covered service which, under the terms of your coverage, must be approved before you receive the covered service.
- **Urgent Care Claim** – A Pre-service Claim which, if decided within the time periods established for making non-Urgent Care Pre-service Claim decisions, could seriously jeopardize your life, health, ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the service.
- **Post-service Claim** – A request for payment or reimbursement of the charges or costs associated with a covered service that you have received.

Coinsurance

The percentage of eligible expenses paid by your plan; the remaining percentage is the percentage you pay.

Copayment

The fixed, up-front dollar amount you pay for certain covered expenses. Copayment amounts do not apply toward your deductible or coinsurance and they do not accumulate toward the out-of-pocket maximum.

Deductible

The initial amount you must pay each year for covered services before the plan begins to pay all or part of the remaining expenses.

Experimental/investigative

The use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not determined by the Claims Administrator or its designated agent to be medically effective for the condition being treated. The Claims Administrator will consider an intervention to be experimental/investigative if: the intervention does not have FDA approval to be marketed for the specific relevant indication(s); or available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes; or the intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; or the intervention does not improve health outcomes; or the intervention is not proven to be applicable outside the research setting. If an intervention, as defined above, is determined to be experimental/investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

Lifetime maximum

The maximum benefit the plan will provide for any covered person during his or her lifetime.

Medically necessary and appropriate

Services or supplies provided by a health care provider that the Claims Administrator determines are: appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury; and provided for the diagnosis or the direct care and treatment of your condition, illness, disease or injury; and in accordance with standards of good medical practice; and not primarily for you or your provider's convenience; and the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered for your condition, and you cannot receive safe or adequate care as an outpatient. The Claims Administrator reserves the right to determine, in its sole judgment, whether a service is medically necessary and appropriate. No benefits will be provided unless the Claims Administrator determines that the service or supply is medically necessary and appropriate.

Out-of-pocket maximum

The highest dollar amount for which you would be responsible each year before the plan begins to pay 100% of all covered expenses. The out-of-pocket maximum does not include copayments, deductibles, mental health/substance abuse expenses, prescription drug expenses, or amounts in excess of the provider's reasonable charge as determined by the Claims Administrator.

Preferred Provider Organization (PPO)

A plan that does not require selection of a primary care physician, but is based on a provider network made up of physicians, specialists, hospitals and other health care facilities. Using the provider network helps assure that you receive maximum coverage for eligible expenses.

UNDERSTANDING the Blue Cross and Blue Shield PPO

In-Network and Out-of-Network Care

Each time you require medical care, you decide whether to receive care from a network provider (in-network) or from any provider of your choice (out-of-network).

- **In-network care** - When you receive covered services from a network provider, benefits are paid at the higher in-network level. You are responsible for any deductible, coinsurance or copayment amounts.
- **Out-of-network care** - When you receive covered services from a provider who is not in the Blue Cross and Blue Shield PPO network, benefits are paid at the lower out-of-network level after you satisfy an annual deductible. You are also responsible for paying any coinsurance amounts, and you may have to pay the difference between the Allowable Amount and the provider's actual charge.

Refer to the Schedule of Benefits for the deductible, coinsurance and copayment amounts applicable to the In-Network and Out-of-Network benefits of your plan.

Blues On Call

Blues on Call is a 24-hour health care advice and assistance service provided by specially trained registered nurses via a toll-free number – 1-888-BLUE428 or 1-888-258-3428. Your call will be kept strictly confidential. If you call about an illness or injury, the nurse listens to your symptoms, makes a comprehensive health care assessment, and helps determine the level of care needed. Depending upon the evaluation, you may be advised to seek emergency care or to call your physician. In some cases, you may be given home health care instructions and the nurse may call you back to check on your progress. You can also call the number for general health inquiries, or to listen to an audiotape on the health care topic of your choice.

Participating and Non-Participating Providers

If you receive services from a health care provider outside the Blue Cross and Blue Shield PPO network, there is another concept you need to understand: *participating* and *non-participating* health care providers.

Participating providers have entered into an agreement with Blue Cross Blue Shield pertaining to payment of benefits for covered services. These providers agree to accept the Blue Cross Blue Shield allowed charge. You will be responsible for any deductibles, coinsurance amounts, copayments, or amounts exceeding maximums. The sum of your payment plus the payment made by the plan will be accepted as payment in full. In the case of professional providers, payment must be made within sixty (60) days of notification by the Claims Administrator. If your payment is not made within sixty (60) days, the participating provider may bill you the difference between the actual charge and the Allowable Charge.

Non-participating providers have not entered into an agreement with Blue Cross Blue Shield pertaining to payment of benefits. When you receive covered services from a non-participating facility provider such as a hospital, the benefit amount will be based on an indemnity allowance as determined by the Claims Administrator. You will be responsible for payment of the remaining charges. Payment for services performed by a non-participating professional provider, such as a physician, will be made to you on the basis of the Allowable Charge. Since non-participating professional providers are not obligated to accept the Allowable Charge as payment in full, you will be responsible for payment of the remaining charges.

Eligible Providers

The following are eligible providers under this plan:

Facility Providers

- Hospitals
- Psychiatric hospitals
- Rehabilitation hospitals

Other Facility Providers

- Alcohol abuse treatment facility
- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Day/Night psychiatric facility
- Drug abuse treatment facility
- Freestanding dialysis facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
- Home health care agency
- Hospice facility
- Outpatient alcohol abuse treatment facility
- Outpatient drug abuse treatment facility
- Outpatient psychiatric facility
- Skilled nursing facility

Professional Providers

- Audiologist
- Certified registered nurse*
- Chiropractor
- Clinical laboratory
- Dentist
- Nurse midwife
- Occupational therapist
- Optometrist
- Physical therapist
- Physician
- Podiatrist
- Psychologist
- Respiratory therapist
- Speech-language pathologist
- Teacher of the hearing impaired

*Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiologist group.

HEALTHCARE MANAGEMENT SERVICES

Healthcare Management Services (HMS), a division of Highmark, is responsible for ensuring that quality care is delivered to you within the proper setting and that the services you receive are medically necessary and appropriate. Precertification or care authorization is required for all inpatient hospital admissions and all inpatient mental health/substance abuse care.

Whether you are to be admitted to an in-network or an out-of-network provider for an inpatient admission *you*, not the provider, are responsible for contacting HMS to receive authorization for your care. Contact HMS by calling the toll-free number on your identification card. You should call 7 to 14 days prior to a planned admission. For emergency or maternity-related admissions, call HMS within forty-eight (48) hours of the admission, or as soon as reasonably possible.

If you do not call to authorize your admission to a facility provider, your care will be reviewed by HMS after services are received to determine if it was medically necessary and appropriate. If the admission is determined not to be medically necessary, you will be responsible for all costs not covered by the plan.

Prospective Review

Prospective review, also known as *precertification*, begins once a request for medical services is received.

After receiving the request for inpatient care, HMS:

- gathers information needed to make a decision, including patient demographics, diagnosis, and plan of treatment;
- confirms care is medically necessary and appropriate;
- reviews available information regarding the member's eligibility for coverage and/or availability of benefits;
- authorizes care or refers to a physician advisor for determination; and
- assigns an appropriate length of stay.

Concurrent Review

Concurrent review may occur during the course of inpatient hospitalization and is used to assess the medical necessity and appropriateness of the length of stay and level of care.

HMS will:

- review patient's progress and ongoing treatment plan with the facility staff; and
- decide, when necessary, to either: extend the patient's care; discuss an alternative level of care; or refer to the physician advisor for a decision.

Discharge Planning

Discharge planning is a review of the case to identify the patient's discharge needs. The process begins prior to a planned admission or, in the case of an unplanned admission, at the time of admission, and extends throughout the patient's stay in a facility. Discharge planning facilitates continuity of care and is coordinated with input from the patient's physician and facility staff.

In planning for discharge, HMS assesses the patient's:

- level of function pre- and post-admission;
- ability to perform self-care;
- primary caregiver and support system;
- living arrangements pre- and post-admission;
- special equipment, medication, and dietary needs and safety needs; obstacles to care;
- need for referral to case management or condition management;
- availability of benefits or need for benefit adjustments; and
- psychological needs.

Retrospective Review

Retrospective review occurs when a service or procedure has been rendered without the required authorization.

Case Management Services

Should you or a covered family member experience a serious injury or illness, the Case Management Program may be able to provide assistance.

If accepted into the program, and with the patient's permission, the program will:

- work collaboratively with the patient, family or significant others, and all providers to coordinate and implement a plan of care which meets the patient's holistic needs;
- identify community-based support and educational services to assist with the patient's ongoing health care needs; and
- assist in the coordination of benefits and alternative resources.

ADDITIONAL UTILIZATION REVIEW PROCESS INFORMATION

Authorized Representatives

You have a right to designate an authorized representative to file or pursue a request for precertification or other Pre-service Claim on your behalf. The Claims Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Procedures adopted by the Claims Administrator will, in the case of an Urgent Care Claim, permit a physician or other professional health care provider with knowledge of your medical condition to act as your authorized representative.

Decisions Involving Requests for Precertification and Other Non-urgent Care Pre-Service Claims

You will receive written notice of any decision on a request for Precertification or other Pre-service Claim whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. That period of time will not exceed fifteen (15) days from the date the Claims Administrator receives the claim. However, this fifteen (15) day period of time may be extended one time by the Claims Administrator for an additional fifteen (15) days provided that the Claims Administrator determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial fifteen (15) day Pre-service Claim determination period. If an extension of time is necessary because you failed to submit information necessary for the Claims Administrator to make a decision on your Pre-service Claim, the notice of extension that is sent to you will specifically describe the information that you must submit. You will have at least forty-five (45) days in which to submit the information.

Decisions Involving Urgent Care Claims

If your request involves an Urgent Care Claim, Highmark will make a decision on your request as soon as possible taking into account the medical emergency involved. You will receive notice of the decision that has been made on your Urgent Care Claim no later than seventy-two (72) hours following receipt of the claim. This time frame may be shortened in those cases where your Urgent Care Claim request seeks to extend a previously approved course of treatment and that request is made at least twenty-four (24) hours prior to the expiration of the previously approved course of treatment. In that situation, the Claims Administrator will notify you of its decision concerning your Urgent Care Claim to extend that course of treatment not later than twenty-four (24) hours following receipt of your request.

Notices of Determination Involving Precertification Requests and Other Pre-service Claims

Any time your request for Precertification or other Pre-service Claim is approved, you will be notified in writing that the request has been approved. If your request for Precertification or approval of any other Pre-service Claim has been denied, you will receive written notification of the denial which will include, among

other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

For a description of your right to file an appeal concerning an adverse determination of a request for Precertification or any other Pre-service Claim, refer to the Appeal Procedure section of this benefit booklet.

CARE AWAY FROM HOME

Your plan also covers care when you're away from home. If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic. If the illness or injury is a true emergency, it will be paid at the in-network benefit level. If the treatment results in a hospital admission, you must contact Healthcare Management Services (HMS) at the number on your identification card to authorize your admission.

If the illness or injury is not an emergency and you receive care from an out-of-network provider, benefits for eligible services will be provided at the lower, out-of-network level.

Dependents Away at School

If your child needs medical care while away at school, it is likely that the care given at the school's medical center is included in tuition costs. If your eligible Dependent needs care that is not provided at the medical center, benefits will be paid at the higher level when care is received from a network provider. If covered services are received from a provider who is not in the network, benefits will be paid at the lower out-of-network level. In the case of an urgent illness or injury that is a true emergency, benefits for covered services will be paid at the higher in-network level.

To receive the maximum benefits of your plan, students and other Dependents temporarily away from home should schedule appointments with network physicians while at home.

BlueCard Worldwide Program

This program provides assistance with medical problems you may incur while traveling outside of the United States. Services include:

- making referrals and appointments for you with nearby physicians and hospitals;
- verbal translation from a multilingual service representative;
- providing assistance if special help is needed;
- making arrangements for medical evacuation services; and
- processing inpatient hospitalization claims.

For outpatient or professional services received abroad, you should pay the provider, then complete an international claim form and send it to the BlueCard Worldwide Service Center. Claim forms can be obtained by calling 1-800-810-BLUE or the Member Service telephone number on your ID card. Claim forms can also be downloaded from www.bcbs.com.

BlueCard Program

When you obtain covered services through BlueCard outside the geographic area Highmark serves, the amount you pay for covered services is calculated on the **lower** of:

- the billed charges for your covered services, or
- the negotiated prices that the on-site Blue Cross Blue Shield Plan ("Host Plan") passes on to Highmark.

Often, this negotiated price will consist of a simple discount which reflects the actual price paid by the Host Plan. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with a health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with a health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over-or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Plan to use a basis for calculating member liability for covered services that does not reflect the entire savings realized, or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted in the paragraph above or require a surcharge, the Claims Administrator would then calculate your liability for any covered services in accordance with the applicable state statute in effect at the time you received care.

HOW YOUR BENEFITS ARE APPLIED

To help you understand your coverage and how it works, you should be familiar with how your benefits are applied and the meaning of a few important terms you will see throughout this section. For specific amounts, refer to the Schedule of Benefits.

Benefit period

Your benefit period is a 12-month period beginning each January 1st. The benefit period may also be referred to as a calendar year.

Copayment

The copayment is the up-front dollar amount you must pay for physician office visits, emergency room visits, outpatient mental health and substance abuse services and prescription drugs. Refer to the Schedule of Benefits for the copayments applicable to your benefit program. The copayment paid does not vary with the cost of the service and does not apply toward the out-of-pocket maximum. *The copayment is to be paid to the provider at the time of service.*

Deductible

The deductible is the amount you must pay for medically necessary and appropriate health care each year before the plan begins to pay all or part of the remaining expenses. Refer to the Schedule of Benefits for the deductible amount(s).

To help participants with several covered dependents, the deductible you pay for the entire family, regardless of its size, is specified under family deductible. To reach this total, you can count the expenses incurred by two or more family members. However, the deductible contributed towards the total by any one family member cannot be more than the amount of the individual deductible. If one family member meets the individual deductible and again needs to use benefits, the plan would begin to pay that person's covered services even if the deductible for the entire family had not been met.

When two or more family members are injured in the same accident, the plan begins to pay benefits when only one family member meets the deductible.

Coinsurance

This is the specific percentage of the provider's reasonable charge you must pay for certain eligible expenses after your deductible, if applicable, has been met. Refer to the Schedule of Benefits to determine the percentage your plan pays; *the remaining percentage is your responsibility.*

Out-of-pocket maximum

This is the amount of money you pay out of your pocket for eligible health care expenses before the plan begins to pay 100% for additional eligible expenses in a calendar year. Refer to the Schedule of Benefits for the out-of-pocket maximum. The individual out-of-pocket maximum applies to each covered person per calendar year. The family out-of-pocket is the amount you have paid out of your own pocket for total covered services your family received during the calendar year. The out-of-pocket maximums do not include copayments, deductibles, mental health/substance abuse expenses, prescription drug expenses, or amounts in excess of the Allowable Charge.

Lifetime maximum

The maximum benefit that the plan will provide for any covered individual during his or her lifetime is specified in your Schedule of Benefits.

At the start of each benefit period, the amount paid for covered services in the proceeding benefit period up to \$1,000 will be restored to the lifetime maximum of each person who used the benefits.

COVERED SERVICES

This plan may not cover all of your health care expenses. Read this benefit booklet carefully to determine which health care services are covered. Please keep in mind that you could be financially responsible for total payment to the provider for any services not covered by this plan.

The plan provides benefits for the following services you receive from a provider only when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copayment amounts are described in the Schedule of Benefits. In-network care is covered at a higher level of benefits than out-of-network care.

Hospital Services

- **Bed, Board and General Nursing Services in:**
 - A semi-private room.
 - A private room. Private room allowance is the average semi-private room charge.
 - A bed in a Special Care Unit which gives intensive care to the critically ill.

- **Other Services:**
 - Operating, delivery and treatment rooms and equipment.
 - Drugs and medicines provided to you while you are an inpatient in a hospital or other facility.
 - Whole blood, administration of blood, blood processing, and blood derivatives.
 - Anesthesia, anesthesia supplies and services rendered in a hospital or other facility provider by an employee of the hospital or other facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery.
 - Medical and surgical dressings, supplies, casts and splints.
 - Diagnostic services.
 - Therapy and rehabilitation services.

- **Emergency Accident Care**
The plan covers outpatient emergency hospital services and supplies to treat injuries caused by an accident.
- **Emergency Medical Care**
The plan covers the initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity to require immediate medical attention.
- **Surgery**
The plan covers hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services furnished by an employee of the hospital or other facility provider other than the surgeon or assistant at surgery.
- **Pre-Admission Testing**
The plan covers outpatient tests and studies required for your scheduled admission as an inpatient.

Surgical/Medical Services

- **Surgical Services**
 - Surgery performed by a professional provider. Payment includes visits before and after surgery.
 - When more than one surgical procedure is performed by the same professional provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure, plus 50% of the amount that would have been payable for each of the additional procedures had those procedures been performed alone.
 - Sterilization and its reversal, regardless of medical necessity and appropriateness.
 - Oral surgical services are limited to:
 - extraction of impacted third molars when partially or fully covered by bone;
 - extraction of teeth in preparation for radiation therapy;
 - mandibular staple implant when not done to prepare the mouth for dentures;
 - maxillary or mandibular frenectomy;
 - accidental injury to the jaw or structures contiguous to the jaw;
 - the correction of a non-dental physiological condition which has resulted in a severe functional impairment;
 - treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of mouth; and
 - orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely side clefts affecting the alveolus.
- **Assistant At Surgery**
The plan covers services of a physician who actively assists the operating surgeon in the performance of a covered surgery if a house staff member, intern or resident is not available.
- **Anesthesia**
The plan covers administration of anesthesia ordered by the attending professional provider and rendered by a professional provider who is not the surgeon or the assistant-at-surgery. Benefits will also be provided for the administration of anesthesia ordered by the attending professional provider and rendered by a professional provider for outpatient oral surgical procedures.
- **Second Surgical Opinion**
The plan covers a second physician's opinion and related diagnostic services to help determine the need for elective covered surgery recommended by your first physician.

Keep in mind that:

- getting a second opinion is your choice;
- your second opinion must be from someone other than the first physician who recommended the surgery;
- elective surgery means non-emergency surgery or surgery that can be deferred; and
- a third opinion is covered if the first and second opinions conflict.

You are covered for surgery even when the physicians' opinions conflict. If the consulting opinion is against the elective surgery and you decide to have the elective surgery, the surgery is a covered service. In such instance, you will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

Inpatient Medical Services

The plan covers the following services you receive from a professional provider when you are an inpatient for a condition not related to surgery, pregnancy, or mental illness:

- **Inpatient Medical Care Visits**
- **Intensive Medical Care**
 - Constant attendance and treatment when your condition requires it for a prolonged time
- **Concurrent Care**
 - Care rendered concurrently with surgery during one hospital stay by a professional provider who is not your surgeon for treatment of a medical condition separate from the condition for which surgery was performed.
 - Care by two or more professional providers during one hospital stay.
- **Consultation**
 - By another professional provider when requested by your attending professional provider
 - Excludes staff consultants required by hospital rules.
- **Newborn care**
 - Care to examine the newborn infant while the mother is an inpatient.

Physician Visits

- **Outpatient Medical Services**

The plan covers the following services you receive from a professional provider:

- outpatient medical care that is not related to surgery, pregnancy or mental illness, except as specifically provided herein; and
- medical care visits and consultations to examine, diagnose and treat an injury or illness; and
- allergy extract and injections.

- **Emergency Accident and Medical Care**

The plan covers treatment of accidental bodily injuries, or initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity to require immediate medical attention.

- **Spinal Manipulations**

The plan covers spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Pediatric Preventive Services (Birth through Age 17)

- **Routine History and Physical Examination**

The plan covers routine pediatric care, including routine physical examinations and routine diagnostic services regardless of medical necessity and appropriateness, *only* when performed by a network provider. Pediatric preventive services covers one examination during each of the following age groupings:

Newborn	12 Months	6 Years	14 Years
1Month	15 to 18 Months	8 Years	15 Years
2 Months	24 Months	10 Years	16 Years
4 Months	3 Years	11 Years	17 Years
6 Months	4 Years	12 Years	
9 Months	5 Years	13 Years	

- **Immunizations**

The plan covers pediatric immunizations when performed and billed by a hospital, other facility provider or professional provider. Benefits are provided for those pediatric immunizations, including the immunizing agents which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Benefits are limited to dependent children and are not subject to program deductibles or maximums.

Women's Care

- **Mammography Screening**

The plan covers one routine mammography screening for women annually, beginning at age 40. Mammographic examinations are covered for all females, regardless of age, when such services are physician prescribed. Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified in accordance with the Mammography Quality Assurance Act of 1992.

- **Routine Gynecological Examination and Pap Test**

The plan covers one routine gynecological examination including a pelvic and clinical breast examination and one routine Papanicolaou smear (pap test) per calendar year for all females regardless of age when such services are physician prescribed. Benefits are not subject to plan deductibles or maximums.

Adult Preventive Services

The plan covers physical examinations for adults 18 years of age and older, regardless of their medical necessity and appropriateness, *only* when performed by a network provider. Covered services include a complete medical history, height and weight measurement, physical examinations and medically necessary diagnostic services needed because of your sex, age and medical background. Immunizations and therapeutic injections required in the diagnosis, prevention and treatment of an injury or illness are also covered.

Diagnostic Services

The plan covers the following services when ordered by a professional provider:

- diagnostic X-ray, consisting of radiology, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine;
- diagnostic pathology, consisting of laboratory and pathology tests;
- diagnostic medical procedures, consisting of electrocardiogram, electroencephalogram, and other electronic diagnostic medical procedures and physiological medical testing approved by the Claims Administrator; and
- allergy testing consisting of percutaneous, intracutaneous, and patch tests.

Therapy and Rehabilitation Services

The plan covers the following services you receive from a professional provider:

- **Physical medicine**

The treatment by physical means or modalities such as, but not limited to, mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and the use of therapeutic exercises and activities, and rehabilitative procedures, performed to relieve pain and restore level of function following disease, illness or injury.

- **Radiation therapy**

The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes.

- **Chemotherapy**

The treatment of malignant disease by chemical or biological antineoplastic agents.

- **Dialysis therapy**

The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body through hemodialysis or peritoneal dialysis. Dialysis treatment includes home dialysis.

- **Respiration therapy**

The introduction of dry or moist gases into the lungs for treatment purposes.

- **Occupational therapy**

The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the persons particular occupational role.

- **Speech therapy**

The treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

- **Infusion therapy**

The treatment by means of infusion therapy when performed by, furnished by and billed by a hospital or facility other provider in accordance with accepted medical practice

- **Cardiac rehabilitation**

The physiological and psychological rehabilitation of patients with cardiac conditions through regulated exercise programs.

ADDITIONAL COVERED SERVICES

Mastectomy and Breast Cancer Reconstruction

The plan covers a mastectomy performed on an inpatient or outpatient basis, as well as surgery to reestablish symmetry or alleviate functional impairment. This includes, but is not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy. Physical complications of all stages of mastectomy are also covered, including lymphedemas. Also covered is the use of initial and subsequent prosthetic devices to replace the removed breast or portions thereof. The plan covers one home health care visit within forty-eight (48) hours after discharge, as determined by your physician, if discharge occurred within forty-eight (48) hours after your admission for a mastectomy.

Family Planning and Infertility Services

The plan covers correction of a physical or medical problem, diagnostic services, counseling, and sterilization procedures such as tubal ligation or vasectomy. Treatment of infertility by means of assisted fertilization techniques such as, but not limited to: artificial insemination, in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), or any method used to enhance the possibility of conception through retrieval or manipulation of the sperm or ovum is **not** covered by the plan.

Maternity Services

The plan covers hospital services and surgical/medical services from a provider for:

- normal pregnancy;
- complications of pregnancy; and
- nursery care.

Maternity Home Health Care Visit

If you are discharged from inpatient care prior to forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean delivery, you are entitled to one maternity home health care visit within

forty-eight (48) hours of discharge. A licensed network health care provider who offers post partum care may provide you with parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and any necessary maternal and neonatal physical assessments. At your discretion, the visit may occur at your provider's facility. Benefits are not subject to the program copayment, coinsurance or deductible amounts, if applicable.

Ambulance Service

- The plan covers local transportation by a vehicle designed, equipped and used only to transport the sick and injured:
 - from your home, scene of accident or medical emergency to a hospital;
 - between hospitals; or
 - between hospital and skilled nursing facility.
 - from a hospital to your home; or
 - from a skilled nursing facility to your home.

Trips must be to the closest local facility that can provide covered services appropriate for your condition. If none, you are covered for trips to closest such facility outside your local area.

Private Duty Nursing Services

The plan covers services of a practicing registered nurse (RN) or licensed practical nurse (LPN) when ordered by a physician providing such nurse does not ordinarily reside in your home or is not a member of your immediate family.

Skilled Nursing Facility Services

The plan covers inpatient hospital services and supplies given to an inpatient of a skilled nursing facility when authorized by the Claims Administrator.

Skilled nursing facility benefits are **not** payable:

- after a patient has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care;
- when confinement is intended solely to assist the member with the activities of daily living or to provide an institutional environment for the convenience of a patient; and
- for treatment of alcohol abuse, drug abuse or mental illness.

Home Health Care/Hospice Care Services

The plan covers the following services you receive from a home health care agency, hospice or a hospital program for home health care, and/or hospice care:

- skilled nursing services of a RN or LPN, excluding private duty nursing services;
- physical medicine, occupational therapy and speech therapy services;
- medical and surgical supplies;
- oxygen and its administration;
- medical social service consultations;
- health aide services when you are also receiving covered nursing or therapy and rehabilitation services;
- respite care; and
- family counseling related to the member's terminal condition.

Home health care benefits are **not** payable for:

- dietician services;
- homemaker services;
- maintenance therapy;
- dialysis treatment;

- custodial care; or
- food or home delivered meals.

Dental Services for Accidental Injury

The plan covers dental services for accidental injury to the jaw, sound natural teeth, mouth or face that occurs on or after your effective date. Injury caused by chewing or biting will not be considered accidental injury.

Durable Medical Equipment

The plan covers the rental (or, at the option of the Claims Administrator, the purchase, adjustment, repairs and replacement) of durable medical equipment for therapeutic use prescribed by a professional provider. Rental costs must not be more than purchase price.

Prosthetic Appliances

The plan covers purchase, fitting, needed adjustment, repairs, and replacement of prosthetic devices and supplies that:

- replace all or part of a missing body organ and its adjoining tissues; or
- replace all or part of the function of a permanently inoperative or malfunctioning body organ.

Dental appliances and the replacement of cataract lenses are *not* covered

Orthotic Devices

The plan covers the purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Transplant Services

The plan covers services furnished by a hospital which are directly and specifically related to the transplantation of organs, bones or tissue. If a human organ, bone or tissue transplant is provided from a living donor to a human transplant recipient:

- when both the recipient and the donor are covered under the plan, each is entitled to the benefits of this plan;
- when only the recipient is covered under this plan, both the donor and the recipient are entitled to the benefits of this plan subject to the following additional limitations: 1) the donor benefits are limited to only those not provided or available to the donor from any other source including, but not limited to, other insurance coverage or any government program, and 2) benefits provided to the donor will be charged against the recipient's coverage under this plan;
- when only the donor is covered under this plan, the donor is entitled to the benefits of this plan, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this plan, and 2) no benefits will be provided to a transplant recipient who is not covered under this plan; and
- if any organ or tissue is sold rather than donated to the covered recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the covered recipient's benefit maximum.

Enteral Formulae

The plan covers Enteral Formulae, which is a liquid source of nutrition administered under the direction of a physician which may contain some or all the nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

Coverage is provided for Enteral Formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. This coverage does not include normal food products used in the dietary management of rare

hereditary genetic metabolic disorders. Benefits for such Enteral Formulae are exempt from any applicable deductible requirements.

Additional coverage for Enteral Formulae is provided when administered on an outpatient basis, when medically necessary and appropriate for your medical condition, when considered to be the sole source of nutrition, and:

- when provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized, instead of regular shelf food or regular infant formulas; or
- when provided orally, and identified as one of the following types of defined formula:
 - with hydrolyzed (pre-digested) protein or amino acids; or
 - with specialized content for special metabolic needs; or
 - with modular components; or
 - with standardized nutrients.

These additional benefits are subject to the program deductible, copayments and maximums. Once it is determined that you meet the above criteria, coverage for Enteral Formulae will continue as long as the Formulae represents at least 50% of your daily caloric requirements.

Additional coverage for Enteral Formulae *excludes* the following:

- blenderized food, baby food, or regular shelf food when used with an enteral system;
- milk or soy based infant formulae with intact proteins;
- any formulae, when used for the convenience of you or your family members;
- nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance;
- the following formulae when provided orally: semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates;
- normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

Diabetes Treatment

The plan covers the following services when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items under the law:

- equipment and supplies such as blood glucose monitors, monitor supplies, injection aids, syringes and insulin infusion devices; and
- Outpatient Diabetes Education when your physician certifies that you require diabetes education as an outpatient. Coverage is provided for the following when rendered through an outpatient diabetes education program*:
 - visits medically necessary and appropriate upon the diagnosis of diabetes; and
 - subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in self-management, or b) identifies as medically necessary and appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes.

*Outpatient Diabetes Education Program is a program of self-management training and education, including medical nutrition therapy, for the treatment of diabetes. Such program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient Diabetes Education services will be covered subject to the criteria of the Claims Administrator. These criteria are based on the certification programs for Outpatient Diabetes Education developed by the American Diabetes Association (ADA) and the Pennsylvania Department of Health (DOH).

Disease State Management

Through the Disease State Management Program, the plan identifies members at risk for certain health problems and provides specific programs of care. You may receive assistance in self-management of health

problems like diabetes, congestive heart failure or chronic obstructive pulmonary disease. Such services may include:

- an evaluation of your physical and psychosocial status;
- development of an individualized treatment plan by a nurse in conjunction with your physician;
- education and training, such as symptom monitoring, medication dosages and compliance, appropriate diet and nutrition, smoking cessation and exercise; and
- ongoing monitoring and treatment modifications.

MENTAL HEALTH AND SUBSTANCE ABUSE CARE

Mental Health Care

The plan covers the following services you receive from a provider to treat mental illness:

- **Inpatient Facility Services**
Covered inpatient hospital services provided by a hospital or other facility provider.
- **Inpatient Medical Services**
Covered inpatient medical services provided by a professional provider.
 - individual psychotherapy;
 - group psychotherapy;
 - psychological testing;
 - counseling with family members to aid your diagnosis and treatment; and
 - electroshock treatment or convulsive drug therapy including anesthesia
- **Partial Hospitalization Mental Health Services**
The plan covers partial hospitalization mental health care services provided by a partial hospitalization program which has been approved by the Claims Administrator. Such programs are subject to periodic review by the Claims Administrator.
- **Outpatient Mental Health Care**
The plan covers services (except room and board) provided by a hospital, other facility provider or professional provider when you are an outpatient.

Substance Abuse Services

The plan covers the following services you receive in a hospital or other facility provider:

- **Inpatient Detoxification** – Up to seven days per admission. The lifetime maximum is four admissions.
- **Inpatient Non-Hospital Rehabilitation** – Up to thirty (30) days per calendar year. The lifetime maximum is ninety (90) days.
- **Outpatient Rehabilitation** – Up to sixty (60) full session visits or equivalent partial visits per calendar year. The lifetime maximum is one hundred twenty (120) visits. A maximum of thirty (30) of these visits may be exchanged on a two-for-one basis to secure up to fifteen (15) additional days per calendar year for inpatient non-hospital rehabilitation services beyond the thirty (30) day limit as referred to above. The additional exchange days are subject to the lifetime limits.

PRESCRIPTION DRUGS

The plan pays for prescription drugs when you purchase them from a **Premier Gold** Network Pharmacy. The pharmacy network includes both major chains and independent stores. *No benefits are available if drugs are purchased from a non-network pharmacy.*

To help contain costs, if a generic drug is available, you will be given the generic. As you probably know, generic drugs have the same chemical composition and therapeutic effects as brand names, and must meet the same requirements of the Food & Drug Administration (FDA). *Should you choose a brand name drug when a generic is available, you must pay the price difference between the brand and generic prices in addition to the applicable copayment or coinsurance amount.*

Covered Drugs

Covered drugs include:

- drugs which, under Federal law, are required to bear the legend: “Caution: Federal law prohibits dispensing without a prescription”;
- legend drugs under applicable state law and dispensed by a licensed pharmacist;
- compounded medications, consisting of a mixture of at least two ingredients other than water, one of which must be a legend drug;
- prescribed injectable insulin;
- diabetic supplies, including needles, and syringes; and
- certain drugs that may require prior authorization from the Claims Administrator.

Covered drugs also include selected prescription drugs within, but not limited to, the following drug classifications only when such drugs are covered medications and are dispensed through an exclusive pharmacy provider. These particular prescription drugs will be limited to your plan’s retail cost-sharing provisions and retail days supply.

These selected prescription drugs may be ordered by a physician or other health care provider on your behalf or you may submit the prescription order directly to the exclusive pharmacy provider. In either situation, the exclusive pharmacy provider will deliver the prescription to you.

- Oncology related therapies
- Interferons
- Agents for multiple sclerosis and neurological related therapies
- Antiarthritic therapies
- Anticoagulants
- Hematinic agents
- Immunomodulators
- Growth hormones
- Fertility drugs

For additional information about drugs that must be obtained through an exclusive pharmacy provider, contact Member Services at the toll-free number on the back of your identification card.

Premier Gold Pharmacy

Premier Gold pharmacies have an arrangement with the Claims Administrator to provide prescription drugs to you at an agreed upon price. When you purchase covered drugs from a pharmacy in the Premier Gold network, present your prescription and identification card to the pharmacist. Prescriptions that the pharmacy

receives by phone from your physician or dentist may also be covered. You should request and retain a receipt for any amounts you have paid if needed for income tax or other purpose.

To determine if your pharmacy is in the network, look for the Premier Gold logo at the store, or call the toll-free Member Services number on your identification card for assistance.

The Premier Gold network also includes mail service suppliers designated by the Claims Administrator. Mail service prescriptions or refills for covered drugs shall be dispensed for not less than a thirty (30) day supply and not more than a ninety (90) day supply. Mail service prescription drug forms may be obtained by calling Member Services at the toll-free number on your identification card.

Prescription drug benefits are not subject to the overall program deductible, coinsurance or maximum. Refer to the Schedule of Benefits for the copayment, coinsurance and/or deductible amounts applicable to your prescription drug program.

Prescription drug benefits are not coordinated against any other health care or drug benefit coverage. In addition, the Plan shall not exercise any subrogation rights against any person or organization for prescription drug charges you incur under this plan.

WHAT IS NOT COVERED

Your plan will not provide benefits for services, supplies or charges:

- Which are not medically necessary and appropriate as determined by the Claims Administrator.
- Which are not prescribed by or performed by or upon the direction of a professional provider.
- Rendered by other than hospitals, other facility providers, professional providers or other professional providers or suppliers.
- Which are experimental/investigative in nature.
- Rendered prior to your effective date of coverage.
- Incurred after the date of termination of your coverage except as provided herein.
- For any illness or injury suffered after your effective date as a result of any act of war.
- For which you would have no legal obligation to pay.
- Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
- To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer you all the benefits of this program and you elect this coverage as primary.
- For any amounts you are required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare supplement coverage.
- For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation.
- To the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran's Administration facilities for services-connected illness or injury unless you have a legal obligation to pay.
- For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle financial Responsibility Act.
- For prescription drugs which were paid or are payable under a freestanding prescription drug program.
- For nicotine cessation support programs and/or classes.
- For methadone hydrochloride treatment for which no additional functional progress is expected to occur.

- Which are submitted by a certified registered nurse and another professional provider or other professional provider for the same services performed on the same date for the same patient.
- Rendered by a provider who is a member of your immediate family.
- Performed by a professional provider or other professional provider enrolled in an education or training program when such services are related to the education or training program.
- For ambulance services, except as provided herein.
- For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law. Other exceptions to this exclusion are: a) surgery to correct a condition resulting from an accident; and b) surgery to correct congenital birth defects; and c) surgery to correct a functional impairment which result from a covered disease or injury.
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or “barrier free” home modifications, whether or not specifically recommended by a professional provider.
- For inpatient admissions which are primarily for diagnostic studies.
- For inpatient admissions primarily for physical medicine services.
- For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care.
- For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, and which are determined not to be medically necessary and appropriate.
- For respite care.
- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided herein.
- For oral surgery procedures except for the treatment of injuries to the jaw, sound and natural teeth, mouth or face, unless specifically provided.
- For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.

- For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
- For hearing aids, tinnitus maskers, or examinations for the prescription or fitting of hearing aids.
- For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery.
- For treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law.
- For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury).
- For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants and LASIX.
- For nutritional counseling, except as provided herein.
- For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate.
- For preventive care services, wellness services or programs, except as provided herein or as mandated by law.
- For well-baby care visits, except as provided herein.
- For allergy testing, except as provided herein or as mandated by law.
- For routine or periodic physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports, or travel, which are not medically necessary and appropriate, except as provided herein or as mandated by law.
- For immunizations required for foreign travel or employment.
- For treatment of sexual dysfunction not related to organic disease or injury.
- For any condition related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, and mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change.
- For any care, treatment or service which has been disallowed under the provisions of the Healthcare Management Services program.
- For any other medical or dental service or treatment, except as provided herein or as mandated by law.

In addition, under your *Prescription Drug benefits*, the following are not covered:

- Services of your attending physician, surgeon or other medical attendant.
- Prescription drugs dispensed for treatment of an illness or an injury for which the group is required by law to furnish hospital care in whole or in part, including, but not limited to, state or federal workers' compensation laws, occupational disease laws and other employer liability laws.
- Prescription drugs to which you are entitled, with or without charge, under a plan or program of any government or governmental body.
- Any charges for therapeutic devices or appliances (e.g. support garments and other non-medical substances).
- Any charge for administration of prescription drugs and/or injectable insulin, whether by a physician or other person.
- Any charges by any pharmacy provider or pharmacist except as provided herein.
- Any drug or medication except as provided herein.
- Any amounts you are required to pay directly to the pharmacy for each prescription or refill.
- Charges for prescription drug when such drug or medication is used for unlabeled or unapproved indications where such use has not been approved by the Food and Drug Administration (FDA).
- Drugs and supplies which are not medically necessary and appropriate or otherwise excluded herein.
- Any retail prescription for more than a thirty-four (34) day supply of drugs; for Mail Service benefits not less than a thirty (30) day supply, nor more than a ninety (90) day supply of covered drugs.
- Any drug that requires refrigeration if delivered through the mail or injectables except insulin and other injectables used to treat diabetes.
- Hair growth stimulants.
- Food supplements.
- Immunizations/biologicals.
- Any drugs used to abort a pregnancy.
- Blood products.
- Antihemophilic drugs.
- Any drugs prescribed for cosmetic purposes only.
- Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes.
- Any drugs which are experimental/investigative.

- Any drugs and supplies which can be purchased without a prescription order, unless specifically described as provided herein.
- Any prescription drugs or supplies purchased at a Non-Participating Pharmacy Provider, except in connection with Emergency Care described herein.
- Any selected diagnostic agents.

MEMBER SERVICES

Identification Card

An identification (ID) card will be issued to you. When you or a covered family member receive health care services, show your ID card to the hospital, pharmacy, or other health care provider and ask the provider to file a claim for you. Your ID card includes the following information:

- your name;
- your ID number;
- group number;
- copayment for physician office visits and emergency room visits;
- Premier Pharmacy network logo;
- Member Services toll-free number (on back of card);
- precertification toll-free number (on back of card).

Only you or your covered family members are permitted to use this card. If your card is lost or stolen, contact Member Services immediately to request a new card.

Member Services Unit

An important component of your program is the dedicated Steelworkers Health and Welfare Fund Member Services unit. Trained representatives are available to assist you by answering any questions you may have about claims or benefits. Call the toll-free Member Services number on the back of your identification card for assistance. Written correspondence may be directed to:

Highmark Blue Cross Blue Shield
P.O. Box 1210
Pittsburgh, PA 15230

Information for Non-English Speaking Participants

If you do not speak English, call the toll-free Member Services number on the back of your identification card to be connected to an AT&T interpreter line for assistance. The Member Services representatives in the dedicated unit are trained to make this connection.

HOW TO FILE A CLAIM

If you receive services from a network provider, you will not have to file a claim. If you receive services from an out-of-network provider, you may be required to file the claim yourself. The procedure is simple. Just take the following steps:

- **Know Your Benefits.** Review this information to see if the services you received are eligible under your medical program.
- **Get an Itemized Bill** – Itemized bills must include:
 - the name and address of the service provider;
 - the patient’s full name;
 - the date of service or supply;
 - a description of the service/supply;
 - the amount charged;
 - the diagnosis or nature of illness;
 - for durable medical equipment, the doctor’s certification;
 - for private duty nursing, the nurse’s license number, charge per day and shift worked;
 - for ambulance services, the total mileage.

Please note: If you have already made payment for the services you received, you must also submit proof of payment (receipt from doctor) with your claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

- **Copy itemized Bills** – You must submit originals, so you will want to make copies for your records. Once your claim is received, itemized bills cannot be returned.
- **Complete a Claim Form** – Make sure all information is completed properly, and then sign and date the form. Claim forms are available from your employee benefits department or Highmark’s Member Services Department.
- **Attach Itemized Bills to the Claim Form and Mail** – After you complete the above steps, attach all itemized bills to the claim form and mail everything to the address on the form.

Remember: Multiple services for the same family member can be filed with one claim form. However, a separate claim form must be completed for each patient.

TIME LIMIT FOR FILING CLAIMS

Your claims must be submitted no later than the end of the calendar year following the calendar year for which benefits are payable. In other words, claims must be submitted no later than December 31st of the year following the date the service was completed.

YOUR EXPLANATION OF BENEFITS

Once your claim is processed, you will receive an Explanation of Benefits (EOB) Statement. This Statement lists: the provider’s charge; allowable amount, copayment, deductible and coinsurance amounts, if any, you are required to pay; total benefits payable; and total amount you owe.

ADDITIONAL INFORMATION ON HOW TO FILE CLAIMS

Member Inquiries

General inquiries regarding your eligibility for coverage and benefits do not involve the filing of a claim, and should be made by directly contacting Member Services at the toll-free number on your identification card.

Filing Benefit Claims

- Authorized Representatives
You have a right to designate an authorized representative to file or pursue a request for reimbursement or other Post-service Claim on your behalf. The Claims Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf.
- Requests for Precertification and Other Pre-Service Claims
For a description of how to file a request for Precertification or other Pre-service Claim, see the Healthcare Management Services section of this benefit booklet.
- Requests for Reimbursement and Other Post-Service Claims
When a participating hospital, physician or other provider submits its own reimbursement claim, the amount paid to that participating provider will be determined in accordance with the provider's agreement with Highmark or the local Blue Cross or Blue Shield Plan serving your area. The Claims Administrator will notify you of the amount that was paid to the provider. Any remaining amounts that you are required to pay in the form of a copayment, coinsurance or program deductible will also be identified in the Explanation of Benefits (EOB) or notice. If you believe that the copayment, coinsurance or deductible amount identified in that notice is not correct or that any portion of those amounts are covered under your benefit program, you may file a claim with the Claims Administrator. For instructions on how to file such claims, you should contact Member Services at the toll-free number on your identification card.

Determinations On Benefit Claims

- Notice of Benefit Determinations Involving Requests for Precertification and Other Pre-Service Claims
For a description of the time frames in which requests for Precertification or other Pre-service Claim will be determined by the Claims Administrator and the notice you will receive concerning its decision, whether adverse or not, see the Healthcare Management Services section of this benefit booklet.
- Notice of Adverse Benefit Determinations Involving Requests for Reimbursement and Other Post-Service Claims
The Claims Administrator will notify you in writing of its determination on your request for reimbursement or other Post-service Claim within a reasonable period of time following receipt of your claim. That period of time will not exceed thirty (30) days from the date your claim was received. However, this thirty (30) day period of time may be extended one time by the Claims Administrator for an additional fifteen (15) days, provided that the Claims Administrator determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial thirty (30) day Post-service Claim determination period. If an extension of time is necessary because you failed to submit information necessary for the Claims Administrator to make a decision on your Post-service Claim, the notice of extension that is sent to you will specifically describe the information that you must submit. You will have at least forty-five (45) days in which to submit the information before a decision is made on your Post-service Claim.

If your request for reimbursement or other Post-service Claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal. For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other Post-service Claim, refer to the following section.

APPEAL PROCEDURE

The Claims Administrator, Highmark, maintains an appeal process involving one level of review. At any time during the appeal process, you may choose to designate a representative to participate in the appeal process on

your behalf. You or your representative shall notify the Claims Administrator in writing of the designation. For purposes of the appeal process described below, "you" includes designees, legal representatives and, in the case of a minor, parents entitled or authorized to act on your behalf. The Claims Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Such procedures as adopted by the Claims Administrator shall, in the case of an Urgent Care Claim, permit a physician or other health care provider with knowledge of your medical condition to act as your representative.

At any time during the appeal process, you may contact Member Services at the toll-free number on your identification card to inquire about the filing or status of your appeal.

If you receive notification that a Claim has been denied by the Claims Administrator, in whole or in part, you may appeal the decision. Your appeal must be submitted in writing (except in cases where the appeal relates to an Urgent Care Claim) and received by the Claims Administrator not later than one hundred eighty (180) days from the date you were notified of the adverse decision.

Upon request to the Claims Administrator, you may review all documents, records and other information relevant to the Claim which is the subject of your appeal and shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal. The appeal will be reviewed by a representative from the Appeal Review Department. The representative shall not have been involved in any previous decision to deny the Claim which is the subject of your appeal or the subordinate of any individual that was involved in that decision. In rendering a decision on your appeal, the Appeal Review Department will take into account all comments, documents, records, and other information submitted by you without regard to whether such information was previously submitted to or considered by the Claims Administrator. The Appeal Review Department will also afford no deference to any prior adverse decision on the Claim, which is the subject of your appeal.

In rendering a decision on an appeal that is based, in whole or in part, on medical judgment, including a determination of whether a requested benefit is medically necessary and appropriate or experimental/investigative, the Appeal Review Department will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Each appeal will be promptly investigated and the Claims Administrator will provide written notification of its decision within the following time frames:

- When the appeal involves a non-Urgent Care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances not to exceed thirty (30) days following receipt of the appeal;
- When the appeal involves an Urgent Care Claim, as soon as possible taking into account the medical exigencies involved but not later than seventy-two (72) hours following receipt of the appeal; or
- When the appeal involves a Post-service Claim, within a reasonable period of time not to exceed sixty (60) days following receipt of the appeal.

In the event the Claims Administrator renders an adverse decision on your appeal, the notification shall include, among other items, the specific reason or reasons for the adverse decision and a statement regarding your right to pursue legal action in accordance with §502 of the Employee Retirement Income Security Act of 1974 (ERISA).

BENEFITS AFTER TERMINATION OF COVERAGE

If you are an inpatient on the day your coverage terminates, inpatient benefits will be continued as follows:

- Until the maximum amount of benefits has been paid; or
- Until the inpatient stay ends; or
- Until you become covered under another group plan; whichever occurs first.

Your benefits will not be continued if your coverage is terminated because you or your Employer failed to pay any required contribution.

Once you are no longer eligible for benefits, you may be able to continue coverage by either electing COBRA coverage, as described in Section I, or by converting to a direct payment health care program.

CONVERSION

If you do not wish to continue coverage by electing COBRA coverage or if you are not eligible for COBRA coverage, you have the opportunity to enroll in a Highmark Direct Payment Program. Conversion is also available to any participant that elected COBRA coverage and the term of that coverage has expired.

If your group coverage is discontinued for any reason, except as specified below, you may convert to a direct payment program. Upon termination of your coverage, information will be sent to you directly from Blue Cross Blue Shield regarding the available conversion plans.

The conversion opportunity is not available if either of the following applies:

- You are eligible for another group health care program through your place of employment; or
- Your employer's program is terminated and replaced by another health care program.

MEDICARE

Active Employees Over Age 65

If you are age 65 or over and actively employed, you will continue coverage under the employer-sponsored plan and receive the same benefits available to employees under age 65. With this option, (a) the employer-sponsored plan will pay all eligible expenses first, and Medicare will then pay for Medicare eligible expenses, if any, not paid for by the employer-sponsored plan; or (b) you may elect Medicare as your primary coverage. If you choose this option, you will not be eligible for any benefit under this plan. Contact your Employer or the Fund Office for specific details.

Spouses Age 65 and Over of Active Employees

If you are actively employed, your spouse has the same choices for benefit coverage as indicated above for the employee age 65 and over.

Regardless of the choice made by you or your spouse, each of you should apply for Medicare Part A coverage three months prior to becoming age 65 to prevent any delay in enrollment. If you choose this plan as your primary coverage while actively employed, you may elect to delay enrolling in Medicare Part B coverage. You will be able to enroll for Medicare Part B later during special enrollment periods, without penalty. Contact your local Social Security Administration office for assistance.

LAWS AFFECTING PLAN BENEFITS

Employees in certain states may be subject to state and federal laws which impact health insurance coverage. The benefits of this plan will be modified to reflect the provision of such laws.

SECTION III: DENTAL BENEFITS

PLAN OVERVIEW

Your Employer has entered into an agreement with the Steelworkers Health and Welfare Fund to provide a dental plan administered by United Concordia Companies, Inc. (UCCI).

This plan covers only services that are dentally necessary. You are ***not required*** to use a provider who participates with UCCI to receive the benefits of the plan; however, a participating provider accepts the decision of the Claims Administrator and will not bill you without your consent for services provided which are determined not dentally necessary. A non-participating provider is not obligated to accept the determination of the Claims Administrator and may bill you for services that are not dentally necessary. You are responsible for these charges when such services are performed by a non-participating provider. You can avoid these charges by choosing a participating provider for your care.

HOW TO FIND A DENTIST

If you would like to know whether or not your provider participates with UCCI, you may simply ask him or her, or call the toll-free Member Services number on the back of your identification card for assistance.

You can also locate a participating dentist via the web at www.unitedconcordia.com. If your dentist has questions about your eligibility or benefits, instruct the office to call Member Services or visit Dental Inquiry at www.unitedconcordia.com.

KEY TERMS

Adverse benefit determination

A denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is experimental or investigational or not medically or dentally necessary or appropriate.

Authorized representative

A person granted authority by you and the Claims Administrator to act on behalf of you regarding a claim for benefit or an appeal of an adverse benefit determination. An assignment of benefit is not a grant of authority to act on your behalf in pursuing and appealing a benefit determination.

Claim for benefits

A request for a plan benefit or benefits by you in accordance with the Claims Administrator's reasonable procedure for filing benefit claims.

Claim involving urgent care

Any claim for dental treatment when the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or in the opinion of a dentist with knowledge of the patient's dental condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Since the Claims Administrator does not require advance approval of emergency care in order to obtain a benefit, there are no claims involving urgent care as defined under the dental plan.

Coinsurance

The coinsurance is the specific percentage of the provider's reasonable charge you must pay for certain eligible expenses after your deductible, if applicable, has been met. Refer to the Schedule of Benefits for the percentage amounts paid by the plan. The remaining coinsurance amounts are your responsibility.

Cosmetic

Procedures which are not dentally necessary and which are undertaken primarily, in the opinion of the Claims Administrator, to improve or otherwise modify the patient's appearance, when the cause is not related to illness or accidental injury.

Deductible

A specified amount of expenses set forth in the Schedule of Benefits for covered services that must be paid by you before the plan will pay.

Dentally necessary

A dental service or procedure as determined by a dentist to either establish or maintain a patient's dental health. Such determinations are based on the professional diagnostic judgment of the dentist and the standards of care that prevail in the professional community. The determination as to when a dental service is necessary shall be made by the dentist in accordance with guidelines established by the Claims Administrator. In the event of any conflict of opinion between the dentist and the Claims Administrator as to when a dental service or procedure is dentally necessary, the opinion of the Claims Administrator shall override that of the dentist.

Experimental or investigative

The use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Claims Administrator, relying on the advice of the general dental community which includes, but is not limited to dental consultants, dental journals and/or governmental regulations, determines are not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which approval has not been granted at the time the services were rendered.

Maximum

The greatest amount the plan is obligated to pay for covered services during a specified period.

Maximum Allowable Charge

The maximum amount the plan will allow for a covered service.

Non-participating provider

A dentist who has not signed a contract with United Concordia Companies, Inc. (UCCI) or an affiliate of United Concordia Companies, Inc. (UCCI).

Participating provider

A dentist who has executed a Participating Dentist Contract with United Concordia Companies, Inc. (UCCI) or an affiliate of United Concordia Companies, Inc. (UCCI) under which he/she agrees to provide covered dental care services under this plan.

Pretreatment estimate/Pre-service claim

The review by the Claims Administrator of a treatment plan to determine eligibility for benefits and the coverage for services in accordance with the Schedule of Benefits, exclusions, limitations and the plan allowance for such services.

Treatment plan

The written report of a series of procedures recommended for the treatment of a specific dental disease, defect or injury, prepared by a dentist as a result of an examination.

PRETREATMENT ESTIMATE

A pretreatment estimate is a review in advance of treatment by the Claims Administrator to determine eligibility and coverage for planned services in accordance with the Schedule of Benefits and the dental plan allowance. A pretreatment estimate is not required to receive a benefit for any service covered under this dental plan; however, it is recommended for extensive, more costly treatment. A pretreatment estimate gives you and your dentist an estimate of your coverage and how much your share of the cost will be for the treatment being considered.

To have benefits estimated, you or your dentist should submit a claim form showing the planned procedures leaving out the dates of service. Be sure to sign the pretreatment request. Substantiating material such as radiographs and periodontal charting may be requested by the Claims Administrator to estimate benefits. The Claims Administrator will determine benefits payable, taking into account exclusions and limitations and alternate treatment options based upon accepted standards of dental practice. You and your provider, if participating in United Concordia's network, will receive an explanation of the estimated benefits.

When the services are performed, simply have your dentist call the Claims Administrator at the number on the back of your identification card, or fill in the dates of service for the completed procedures on the pretreatment notification and re-submit it to the Claims Administrator for processing. Any pretreatment estimate by the Claims Administrator is subject to your continued eligibility for benefits. The Claims Administrator may also make adjustments at the time of final payment to correct any mathematical errors, apply coordination of benefits, and comply with the plan in effect and remaining program maximum dollars at date of services.

ALTERNATE TREATMENT

Frequently, your dentist can choose from several alternate methods of treating a particular dental problem. For example, a tooth can be restored with either a crown or a filling; and missing teeth can be replaced with either a fixed bridge or a partial denture. In cases where alternate methods of treatment are possible and professionally acceptable, the Claims Administrator will make payment based on its allowance for the less expensive procedure *provided that the less expensive procedure meets the accepted standards of dental treatment*. Whenever this alternate benefit provision is applied, a Dental Advisor reviews the claim.

The Claims Administrator's decision on the allowance it will pay does not commit you to the less expensive procedure. You may decide to have the more costly treatment and to be responsible for the additional charges beyond those for the treatment paid by the Claims Administrator.

EXPERIMENTAL TREATMENT

Your plan does not cover services that the Claims Administrator determines are experimental or investigative in nature. Experimental and investigative services are those that the general dental community (dental consultants, dental journals and/or governmental regulations) determine are not acceptable standard dental treatments of the condition for which care is being provided. However, situations may occur when you and your professional provider agree to pursue an experimental treatment. If your professional provider performs an experimental procedure, you are responsible for the charges. You or your professional provider may contact the Claims Administrator to determine whether a service is considered experimental or investigative.

SERVICES THAT DO NOT MEET ACCEPTED STANDARDS OF DENTAL PRACTICE

Your plan will not pay for services that are considered unusual procedures or techniques or for which supplies or other services are used that do not meet the accepted standards of dental practice. A participating provider accepts the decision of the Claims Administrator and will not bill you for these services without your consent. A non-participating provider, however, is not obligated to accept this determination and may bill you for such services. You are responsible for these charges when performed by a non-participating provider.

ANNUAL AND LIFETIME MAXIMUMS

The annual and lifetime maximum benefits payable for covered services under this plan are identified in the Schedule of Benefits. All covered services, except orthodontics, are subject to a calendar year maximum. Orthodontics is subject to a separate lifetime maximum.

EXTENSION OF BENEFITS

Benefits for completion of a dental procedure, requiring two or more visits on separate days, will be extended for a period of ninety (90) days after termination of coverage. In the case of orthodontic treatment, if the orthodontist has agreed to or is receiving monthly payments, the extension of coverage shall be for sixty (60) days. However, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis, coverage will be extended to the end of the quarter in progress or sixty (60) days, whichever is later.

PAYMENT OF BENEFITS

Payment for covered services performed by participating providers will be made to the dentist on the basis of a percentage of the Maximum Allowable Charge (MAC) or the amount charged, whichever is less. The Maximum Allowable Charge (MAC) is the maximum amount the plan will allow for a covered service as determined by the Claims Administrator from national and regionalized data. A participating provider must accept the Claims Administrator's allowance as payment in full for covered services. You are responsible for any coinsurance, deductibles and amounts exceeding the maximum or any service not covered by the plan. The sum of your payment and the Claims Administrator's payment will be accepted as payment in full, provided that your portion of the payment is made to the participating provider within 60 (sixty) days of notification by the Claims Administrator. If your payment is not made within 60 (sixty) days, the participating provider may bill you the difference between the charge and the MAC allowance.

Payment for covered services performed by a non-participating provider will be made to you on the basis of a percentage of the MAC allowance or the amount charged, whichever is less. Non-participating providers are not obligated to accept the MAC allowance as payment in full. Such payment will constitute full discharge of the Claims Administrator's responsibility under the plan. You are responsible for payment of the remaining charge.

Benefits will be provided for eligible dental services when billed by the licensed dentist in charge of the case. This professional care can be performed anywhere unless otherwise indicated.

COVERED SERVICES

The plan covers the following services provided by a licensed dentist provided they are deemed dentally necessary by the Claims Administrator. Refer to the Schedule of Benefits for the percentage amounts payable for covered services.

Diagnostic Services

- Routine oral examinations, but not more than once in any period of 6 (six) consecutive months.
- Dental X-rays
 - Full mouth X-rays, but not more than once every three years.
 - Bitewing X-rays, but not more than once in any period of six consecutive months.
 - Periapical X-rays as required.
- Palliative emergency treatment of an acute condition requiring immediate care.

Preventative Services

- Routine prophylaxis (including cleaning, scaling and polishing of teeth), but not more than once in any period of six consecutive months.
- Topical Fluoride application for eligible dependent children under 19 years of age, but not more than once in any period of six consecutive months.
- Space Maintainers (not made of precious metal) that replace prematurely lost teeth for eligible dependent children under 19 years of age.
- Sealants for eligible dependent children through age 10 on permanent first molars and through age 15 on permanent second molars only if teeth to be sealed are free of proximal caries and there are no previous restorations on the surface to be sealed. One sealant per tooth per three- year period.

Minor Restorations

- Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth.
- Composite restorations on posterior teeth will be limited to the allowance for amalgam restoration. The balance of the cost is your responsibility.

General Services

- Repair of broken partial or full removable dentures.
- Simple extractions.
- Endodontics, including pulpotomy and root canal treatment.
- Administration of anesthesia in connection with covered services when rendered by or under the direct supervision of a dentist other than the surgeon, assistant surgeon or attending dentist.
- Inpatient consultations if the condition requires it and the dentist in charge of the case requests the consultation. You are limited to one consultation per consultant during any one inpatient stay.

Oral Surgery

- Surgical removal of teeth.
- Surgical removal of maxillary or mandibular intrabony cysts.
- Procedures performed for the preparation of the mouth for dentures.
- Apicoectomy (surgical removal of the end of a root.)
- Services of a dentist who actively assists the operating surgeon in the performance of covered surgery when the condition of the patient or the type of surgery performed requires assistance. Surgical assistance is not covered when performed by a dentist who himself performs and bills for another surgical procedure during the same operative session.

Prosthetics, Crowns, Inlay and Onlay Restorations

Coverage for prosthetics, crowns, inlays and onlays may be limited to the least expensive but adequate treatment plan, consistent with established dental standards. A more expensive treatment plan than that covered under this dental plan may be selected with the understanding that you will be responsible for paying the difference in cost between the treatment received and the Claims Administrator's allowance.

- Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays).
- Initial insertion of partial or full dentures (including any adjustments during the six month period following insertion).
- Replacement of an existing partial or full denture or bridge by a new denture or by a new bridge, but only if satisfactory evidence is presented that:
 - the existing denture or bridge was inserted at least five years prior to replacement; and
 - the existing denture or bridge is not serviceable and cannot be made serviceable. If the existing denture or bridge can be made serviceable, payment will be made toward the cost of the services that are necessary to render such appliance serviceable.
- Single unconnected crown, inlays and onlays (none of which is part of a bridge or are splinted together).
- Replacement of crowns, inlays and onlays, but only if satisfactory evidence is presented that at least five years have elapsed since the date of the insertion of the existing crown, inlay or onlay and that the appliance is not serviceable and cannot be made serviceable.
- The addition of teeth to an existing partial denture or to a bridge, but only if satisfactory evidence is presented that the addition of teeth is required to replace one or more teeth extracted after the existing denture or bridge was inserted.
- Relining or rebasing of dentures more than six months after the insertion of an initial or replacement denture, but not more than one relining or rebasing in any period of thirty-six (36) consecutive months.
- Repair of broken crowns, inlays, onlays or bridges.

Periodontal Services

- Diagnosis and treatment planning including periodontal examinations.
- Nonsurgical periodontal therapy including periodontal scaling and root planing.
- Surgical periodontal therapy.
- Maintenance – post-treatment preventive periodontal procedures (periodontal prophylaxis).

Orthodontics

- Diagnosis, including radiographs
- Active treatment, including necessary appliances
- Retention treatment following active treatment

Notwithstanding any other provision in this booklet, the Claims Administrator shall make payment for orthodontics in accordance with the coinsurance percentage previously specified. The amount of the Claims Administrator's liability shall be payable over a period not to exceed the length of the approved Treatment plan. Payments will be made no more frequently than once every three months. If the Treatment plan is satisfactorily completed in less than the period specified in the approved Treatment Plan, the Claims Administrator shall, upon appropriate notification from the dentist, make payment in the amount of the remainder of the Claims Administrator's liability.

EXCLUSIONS AND LIMITATIONS

Your plan will not provide benefits for services, supplies or charges:

- Not specifically listed as a covered benefit.
- Which in the opinion of the dentist are not clinically necessary for the patient's health.
- Which are necessitated by lack of patient cooperation or failure to follow a professionally prescribed Treatment plan.
- Started by any dentist prior to the patient's eligibility under the plan, including, but not limited to: endodontics, crowns, bridges, inlays, onlays and dentures.
- Incurred prior to the patient's effective date or after the termination date of coverage under the plan, except those services as provided for in the Extension of Benefits section.
- That do not meet accepted standards of dental treatment, which are experimental or investigational in nature or are considered enhancements to standard dental treatment as determined by the Claims Administrator.
- For hospitalization costs.
- Determined by the Claims Administrator to be the responsibility of Worker's Compensation or Employer's Liability, services for which benefits are covered under any Federal Government or state program, excluding Medical Assistance, or for services for treatment of any automobile related injury in which the patient is entitled to payment under an automobile insurance policy. The plan's benefits would be in excess to the third party benefits and therefore, the Plan would have the right to recovery for any benefits paid in excess.
- For prescription drugs.
- Administration of nitrous oxide, general anesthesia and IV sedation, except as specifically included under Covered Services.
- Which are cosmetic in nature as determined by the Claims Administrator.
- Elective procedures including the prophylactic extraction of third molars within the first six months of enrollment.
- For the following that are not included as orthodontic benefits: retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect.
- For any dental or medical services performed by a physician and/or services for which benefits are otherwise provided under a Medical-Surgical plan of the patient.
- For congenital mouth malformations or skeletal imbalances, including, but not limited to: treatment related to cleft palate therapy, treatment related to disharmony of facial bone, treatment related to or required as the result of orthognathic surgery including orthodontic treatment, dental implant services including placement and restoration of implants, and oral and maxillofacial and temporomandibular joint services including associated hospital, facility, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth, all treatment of

temporomandibular disorders (TMD, TMJ, CMD, MFPD, etc.), both surgical and nonsurgical treatment, arthroscopy of the joint and orthognathic surgery, and treatment of any malocclusion involving joints or muscles by orthodontic repositioning of the teeth. This exclusion shall not apply to newly born children of participants.

- For dental treatment of fractures and dislocations of the jaw except as a result of accidental injury.
- For treatment of malignancies or neoplasms.
- Procedures requiring appliances or restorations (except when involving full or partial dentures or correction of a dental condition as a result of accidental injury) that are necessary for adult or pediatric full mouth rehabilitation, including precision attachments or stress breakers, restoration of occlusion, to alter vertical dimension of occlusion, restorative equilibration and kinesiologly.
- For the cost to replace lost, stolen or damaged prosthetic or orthodontic appliances.
- Deemed by the Claims Administrator to be of questionable efficacy.
- For broken appointments.
- Which are not dentally necessary as determined by the Claims Administrator.
- Arising from any intentionally self-inflicted injury or contusion, or as a consequence of the patient's commission of or attempt to commit a felony or engagement in an illegal occupation or of the patient's being intoxicated or under the influence of illicit narcotics.
- For house calls for dental services.
- For any services for which the patient failed to follow the guidelines of the plan.

The following services will be subject to the limitations set forth below:

- Full mouth x-rays – one every three years.
- One set of bitewing x-rays per consecutive six months.
- Periodic oral evaluation – one per six months.
- Prophylaxis – one per six months.
- Fluoride treatment – one per six months through age eighteen.
- Space maintainers – only provided for eligible dependent children through age eighteen when used to maintain space as a result of prematurely lost deciduous posterior teeth and permanent first molars, or deciduous posterior teeth and permanent first molars that have not, or will not develop.
- Prefabricated stainless steel crowns – one per tooth per lifetime for age fourteen years and younger.
- Crown lengthening – one per tooth per lifetime.

- Periodontal maintenance following active periodontal therapy – four in any twelve (12) consecutive months per patient reduced by the number of routine prophylaxis received during that twelve (12) month period so that total prophylaxes for the period does not exceed four.
- Periodontal scaling and root planing – one per twenty-four (24) month period per area of the mouth.
- Placement or replacement of single crowns, single and abutment buildups and post and cores, bridges, full and partial dentures – one within five years of their placement.
- Denture relining or rebasing – integral if provided within six months of insertion by the same dentist.
- Subsequent denture relining or rebasing – limited to one every thirty-six (36) months thereafter.
- Surgical periodontal procedures – one per twenty-four (24) month period per area of the mouth.
- Sealants – one per tooth per three years through age ten on permanent first molars and through age fifteen on permanent second molars.
- Pulpal therapy – through age five on primary anterior teeth and through age eleven on primary posterior teeth.
- Root canal therapy – limited to one per tooth per lifetime.
- Inlays, onlays, crowns, dentures and bridges shall be considered completed on the date they are finally inserted.
- One consultation per consultant during any one year period.
- If for any reason orthodontic services are terminated before completion of approved treatment, the liability of the plan will cease with payment through the month of termination.
- Functional/myofunctional therapy is covered only when provided by a dentist in conjunction with appliance therapy.

CLAIMS SUBMISSION AND PAYMENT

Upon completion of treatment, a claim needs to be filed with the Claims Administrator. If you visit a participating provider, the dental office will submit claims for you. The Claims Administrator will pay covered benefits directly to the participating provider. Both you and the dentist will receive an explanation of benefits. Claim forms may be obtained by calling Member Services at the toll-free number on your identification card.

Most dental offices submit claim forms for patients. However, if you do not receive treatment from a participating provider, you may have to complete and send a claim form to the Claims Administrator in the event the dental office will not do this for you. Submit the claim or pretreatment estimate to the address on the claim form. Be sure to include the patient's name, date of birth, your ID number, patient's relationship to you, your name and address, and the name and policy number of a second insurer if the patient is covered by another dental plan. Your dentist should complete the treatment and provider information, or supply an itemized receipt for you to attach to the claim form. The Claims Administrator will forward payment to you if covered services are provided by a non-participating provider and you do not indicate on the claim that you

wish payment to be sent to the dentist. You will receive an explanation of benefits detailing how the claim was paid, including any deductibles and copayments which were applied.

TIME LIMIT FOR FILING LAIMS

Claims must be submitted to the Claims Administrator within ninety (90) days of the date of service or as soon as reasonably possible and, in no event, later than one year from the time the service was performed.

NOTICE OF ADVERSE BENEFIT DETERMINATION

The Claims Administrator will determine benefits and notify you of adverse benefit determinations no later than thirty (30) days after receipt of the claim.

The Claims Administrator may extend this thirty (30) day period by fifteen (15) days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Claims Administrator. The Claims Administrator will notify you of the extension before the end of the initial thirty (30) day period. The Claims Administrator will explain the circumstances requiring the extension, the additional information required and the date by which the Claims Administrator expects to make the benefit determination. You will have forty-five (45) days to provide the information requested. The time it takes you to respond to the request for additional information will not be counted toward the time the Claims Administrator is required to make the benefit determination.

If your request for reimbursement or other Post-service Claim is denied, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal. For a description of your right to file an appeal concerning an adverse benefit determination of a request for reimbursement or any other Post-service Claim, refer to the following section.

CLAIMS APPEALS

The Claims Administrator will make benefit determinations and resolve appeals in a thorough, appropriate, and timely manner to ensure that you are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the plan documents and consistently among claimants. You or your authorized representative may submit written comments, documents, records and other information relating to claims or appeals. The Claims Administrator will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by the Claims Administrator required under these procedures will be supplied to you or your authorized representative.

If you are dissatisfied by the benefit determination, in whole or in part, you or your authorized representative may file an appeal with the Claims Administrator within one hundred eighty (180) days of receipt of the adverse benefit determination. To file an appeal, call the toll-free number listed on your notice of adverse benefit determination.

The Claims Administrator will review your appeal and notify you of its decision within sixty (60) days following your request for the appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination.

SECTION IV: VISION BENEFITS

PLAN OVERVIEW

Your Employer has entered into an agreement with the Steelworkers Health and Welfare Fund to provide a vision plan that is administered by Davis Vision, Inc. This plan, which is called the Annual Plan, provides benefits for covered services from any eligible vision provider. You ***are not*** required to use a provider who participates with Davis Vision to receive benefits. You will, however, receive the greatest value and maximize your benefits if you choose a provider who participates in Davis Vision's Provider Network.

ELIGIBLE PROVIDERS OF SERVICE

The following professional providers of vision services are eligible under this plan:

- Ophthalmologists
- Optometrists
- Opticians

You may use either a network provider or an out-of-network provider for covered vision services. Providers who have entered into a contract with Davis Vision to provide eye examinations and/or materials on a scheduled fee basis are network providers. Providers of optometric services who have *not* entered into a contract with Davis Vision to provide vision care services are out-of-network providers.

HOW TO FIND A NETWORK PROVIDER

The Davis Vision network includes providers in both private practice and retail locations. To locate a network provider near you, contact member services at the number on your identification card or you can go online to www.davisvision.com and use the "Find a Doctor" feature.

COVERED SERVICES

The plan covers charges by an eligible provider for the following services. The benefits payable for covered services vary depending upon whether the services are rendered by a network provider or an out-of-network provider. Refer to the Schedule of Benefits in this section for plan benefits, frequency limitations and the amounts you will owe for covered services.

Eye Examination

- Case history
- Entrance distance acuities
- External ocular evaluation including slit lamp examination
- Internal ocular examination
- Tonometry
- Distance refraction – objective and subjective
- Binocular coordination and ocular motility evaluation
- Evaluation of papillary function
- Biomicroscopy
- Gross visual fields
- Assessment and plan

Fitting of Eyeglasses, including follow-up adjustments

Materials

- Glass or plastic lenses in single vision, bifocal, trifocal or lenticular prescriptions, including oversized lenses and cataract lenses
- Contact lenses, including evaluation and fitting
- Medically necessary contact lenses for the correction of Keratoconus
- Frames from Davis Vision's Fashion Advantage Collection

Frames and lenses from an out-of-network provider or from a network provider's own collection are payable up to the allowances shown on the Schedule of Benefits. Any amount due in excess of the allowance and/or maximum for covered lenses or frames is your responsibility.

Note: The benefit for medically necessary contact lenses for the correction of Keratoconus is available both in and out-of-network and requires prior approval. You or your provider must obtain this approval from Davis Vision before the lenses are dispensed. If the required approval is not obtained, no benefits will be paid for contact lenses for the correction of Keratoconus and the entire charge will be your responsibility. Any amount due in excess of the allowance and maximums for covered contact lenses for the correction of Keratoconus shown on the Schedule of Benefits is your responsibility.

Low Vision Program

- Comprehensive low vision evaluation in addition to an eye examination when the eye examination indicates a need for such an evaluation
- Follow-up visits
- Low vision aids

Note: The low vision program is available both in and out-of-network and requires prior approval. You or your provider must obtain this approval from Davis Vision prior to the initial low vision evaluation. If the required approval is not obtained, no benefits will be paid for any low vision services and the entire charge will be your responsibility. Any amount due in excess of the allowance and maximums for covered low vision services shown on the Schedule of Benefits is your responsibility.

Optional In-Network Items

- Glass Grey #3 prescription lenses
- Fashion, sun and gradient tinted plastic lenses
- Scratch resistant coating
- Designer Frame
- Premier Frame
- Ultraviolet Coating
- Photochromic Lenses
- Blended Invisible Bifocals
- Progressive Addition Lenses
- Anti-Reflective Coating
- Polycarbonate Lenses
- Polarized Lenses
- High Index Lenses
- Plastic Photosensitive Lenses

Your cost for any optional in-network item is limited to the applicable discounted fixed fee shown on the Schedule of Benefits.

SPECIAL FEATURES

- Discounts on Laser Vision Correction Services from network providers.
- A mail order replacement contact lens service, *Lens 123*, for the purchase of replacement contact lenses at significant savings.
- A one year unconditional breakage warranty for all eyeglasses completely supplied through the Davis Vision Collection

For more information about these value-added features, visit www.davisvision.com or call 1-800-299-1910. For more information on the contact lens replacement service, visit www.Lens123.com or call 1-800-536-7123.

PAYMENT FOR COVERED SERVICES

Payment for covered services by a network provider is made on a scheduled fee basis. This is the amount negotiated between the network provider and Davis Vision as full payment for eye examinations, the fitting of eyeglasses and materials you receive or purchase. Payment for covered services by an out-of-network provider is made on the basis of the Usual and Customary Charge as determined by Davis Vision. The Usual and Customary Charge is that portion of a charge that does not exceed the lesser of:

- The customary charge made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area; or
- The usual charge the provider most frequently makes to patients for the same service.

Out-of-network providers may bill you for the difference between the allowance shown on the Schedule of Benefits and the provider's actual charge for the covered service.

LIMITATIONS

- Payment for an eye examination and refraction is limited to once every twelve (12) months.
- Payment for contact lens prescription and fitting is limited once every twelve (12) months.
- Payment is limited to one set of frames in any twelve (12) month period.
- Payment for lenses or contact lenses is limited to once every twelve (12) months.
- Payment will not be made for both contact lenses and eyeglasses within the same twelve (12) month period.

EXCLUSIONS

Your plan will not provide benefits for services, supplies or charges:

- For services or supplies not recommended by a covered provider.
- For periodic vision examinations, except as provided herein.
- For eye examinations required by an employer as a condition of employment.
- For services or materials provided in connection with special procedures such as orthoptics and visual training, or in connection with medical or surgical treatment.
- For lenses which do not provide vision correction.
- For charges for the replacement of lost or stolen lenses or frames within twenty-four (24) months of service.
- For sickness or injury covered by a worker's compensation act or other similar legislations.
- Incurred as a direct or indirect result of war (declared or undeclared).
- Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.
- For services or supplies furnished to you before the date your coverage is effective or after the date your coverage ends.
- For services or supplies which are not generally accepted in the United States as being necessary and appropriate.
- For any medical treatment rendered outside the United States or Canada.
- For services rendered by practitioners who are not covered providers under this plan.
- For any expenses covered by any union welfare plan or governmental program or a plan required by law.

- For comprehensive low vision evaluations, subsequent follow-up visits following such evaluation or low vision aids for which prior approval was not obtained from Davis Vision.
- For medically necessary contact lenses prescribed for Keratoconus for which prior approval was not obtained from Davis Vision.
- For expenses covered by any other group insurance or a health maintenance organization or hospital or medical services prepayment plan available through an employer, union or association.

HOW TO FILE A CLAIM

If you use a network provider, there are no claim forms to fill out. Simply show your ID card at the time you receive the services. The provider will verify your eligibility for benefits and submit your claim directly to Davis Vision. All benefits for network services will be paid directly to the provider.

If you use a provider who is out-of-network, you must pay the provider directly and then submit a claim for reimbursement. Benefits for out-of-network services will be paid to you.

To request claim forms you can visit the Davis Vision website at www.davisvision.com or call member services at 1-800-299-1910. Send your completed claim forms to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

TIME LIMIT FOR FILING CLAIMS

Claims must be submitted within ninety (90) days of the date of service, or as soon thereafter as reasonably possible.

NOTICE OF ADVERSE BENEFIT DETERMINATION

Davis Vision, the Claims Administrator, will determine benefits and notify you of adverse benefit determinations no later than thirty (30) days after receipt of a claim. This initial thirty (30) day period may be extended by fifteen (15) days if additional information about the claim is required or the extension is necessary due to matters beyond the control of the Claims Administrator. The Claims Administrator will notify you of the extension before the end of the initial thirty (30) day period, and will explain the circumstances requiring the extension, the additional information required and the date by which the Claims Administrator expects to make the benefit determination. You will have forty-five (45) days to provide the information requested. The time it takes you to respond to the request for additional information will not be counted toward the time the Claims Administrator is required to make the benefit determination.

If your request for reimbursement is denied, you will receive written notification of that denial within a reasonable period of time which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

APPEAL PROCEDURES

You have the right to appeal any determination made by the Claims Administrator with which you disagree. Your appeal must be filed within one hundred eighty (180) days of receipt of the adverse benefit determination. To file an appeal, call the toll-free number on your notice of adverse benefit determination. No special form is required to file an appeal.

Your appeal will be reviewed by the Member Appeal committee and will not involve any individual or the subordinate of any individual that participated in any prior decision concerning the claim which is the subject of your appeal. If a decision on your appeal is based in whole or in part on medical judgment, the Member Appeal committee will consult with a licensed physician in the same or similar specialty that typically manages or consults on the vision care service involved prior to making a decision on your appeal. The vision care professional providing the consultation will not have participated in or be the subordinate of any individual that participated in any prior decision to deny the claim which is the subject of your appeal.

You may, upon request, review all documents, records and other information that may be relevant to your appeal. Upon request, copies of all such materials will be made available to you free of charge. In addition, the identity of any physician or medical expert whose advise was obtained in connection with the initial determination to deny your claim, whether or not that advise was relied upon, will be made available to you upon request and free of charge. You also have the right to submit any written data, comments, documents, records and other information that you wish to have the Member Appeal Committee consider prior to rendering a decision on your appeal.

Your appeal will be promptly investigated and decided. The Member Appeal Committee will consider all of the comments, documents, records, reports and other information that have been made available and will not afford deference to any prior decision that has been made to deny your claim. Written notification of the decision will be provided with a reasonable period of time appropriate to the circumstances, not to exceed thirty (30) days following receipt of your appeal.

If your appeal relates to an adverse benefit determination on a reimbursement or other post-service claim, written notification of the decision will be provided within a reasonable period of time not to exceed sixty (60) days following receipt of your appeal. The notification will include, among other items, the reasons for the decision and your right to pursue a voluntary appeal and/or to pursue legal action, if necessary.

Designation of an Authorized representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. If you do so, you must notify Davis Vision in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number and a statement indicating the extent to which he or she is authorized to pursue the claim and/or file an appeal on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

SECTION V: COORDINATION OF BENEFITS AND SUBROGATION

COORDINATION OF BENEFITS

Most group health care plans, including this Plan, contain a *coordination of benefits* provision. This provision is used when you or your Dependents are eligible for payment under more than one group health plan. The object of coordination of benefits is to assure you that your covered expenses will be paid, while preventing duplicate benefit payments. Here is how the coordination of benefits provision in this plan works:

- If you or your Dependents are eligible to receive benefits under another group health plan, benefits under this plan will be coordinated with the benefits from any other group health plan so that not more than the provider's reasonable charge for covered services will be paid by this plan.
- When your other group coverage does not mention coordination of benefits, then that coverage pays first. Benefits paid or payable by the other group coverage will be taken into account in determining if additional benefit payments can be made under this plan.
- When the person who received care is covered as an Employee under one plan and as a Dependent under another, the plan under which the person is covered as an Employee is primary and pays first.
- When a child is covered under two group plans, the plan covering the parent whose birthday falls earlier in the calendar year is primary and pays first. If both parents have the same birthday, the plan which covered the parent longer will be the primary plan.
- If you and your spouse are separated or divorced, the following applies to your children:
 - If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
 - If the divorced parent with custody has remarried, the coverage of the parent with custody pays first, but the stepparent's coverage pays before the coverage of the parent who does not have custody.
 - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:

- (a) the benefits of a plan covering the person as an employee other than a laid-off or retired employee or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person; and
- (b) if the other plan does not have a provision regarding laid-off or retired employees and, as a result, the benefits of each plan are determined after the other, then the provisions of (a) above shall not apply.

If you receive more than you should have when your benefits are coordinated, you will be expected to repay any overpayment. Coordination of benefits prevents duplication and works to the advantage of all members of the Plan.

SUBROGATION

If the Fund makes payment for a Benefit on account of sickness or accidental bodily injury, and you recover monies from another source on account of or in connection with that sickness or accidental bodily injury, you are responsible for reimbursing the Fund any monies paid by another source up to the amount paid by the Fund. If legal action is instituted against any such other source, the Fund is entitled to intervene and participate in that action. If you do not institute legal action, the Fund may do so in your name. If you are injured through an act or omission of another party (for example, a car accident) or where another person is otherwise responsible for your sickness or accidental bodily injury, benefits under this Fund will be provided in connection with that sickness or accidental bodily injury only if you agree in writing to:

- reimburse the Fund (to the extent of benefits provided) immediately upon receipt of any payment from any other source on account of or in connection with such sickness or accidental bodily injury; and
- authorize the insurance carrier for the responsible party (or the uninsured motorist or no-fault insurance carrier) to make payment to the Fund to the extent of benefits provided; and
- provide the Fund with a lien against any monies recovered as described in paragraph 1 above; and
- authorize the Fund to intervene in any suit or other proceedings against a responsible party as described above, and/or to institute such legal action in your name in the circumstances described above.

The foregoing provisions shall also apply to your Dependents with respect to benefits provided to them.

SECTION VI: FUND PRIVACY POLICY

NOTICE OF PRIVACY PRACTICES

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

THE FUND'S COMMITMENT TO PRIVACY

The Steelworkers Health and Welfare Fund (the "Fund") is committed to protecting the privacy of the information it maintains that identifies you and relates to your physical or mental health, or to the provision or payment of health services for you ("health information"). In accordance with applicable law, you have certain rights, as described in this Notice, related to your health information.

This Notice informs you of the Fund's legal obligations under the federal health privacy provisions contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the related regulations ("federal health privacy law"):

- to maintain the privacy of your health information;
- to provide you with this Notice describing the Fund's legal duties and privacy practices with respect to your health information; and
- to follow the terms of this Notice.

This Notice also informs you how the Fund uses and discloses your health information and explains the rights that you have with regard to your health information maintained by the Fund. For purposes of this Notice, "you" or "your" refer to Participants and Dependents who are eligible for benefits under the Fund.

INFORMATION SUBJECT TO THIS NOTICE

The Fund collects and maintains certain health information about you to help provide health benefits to you, as well as to fulfill legal and regulatory requirements. The Fund obtains this health information from applications and other forms that you complete, through conversations you may have with the Fund's administrative staff, and from reports and data provided to the Fund by health care service providers. This is the information that is subject to the privacy practices described in this Notice. The health information the Fund has about you includes, among other things, your name, address, phone number, birthdate, social security number, employment information, and medical and health claims information.

SUMMARY OF THE FUND'S PRIVACY PRACTICES

The Fund's Uses and Disclosures of Your Health Information

The Fund uses your health information to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. The Fund discloses your health information to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Fund may also disclose your health information to third parties that assist the Fund in its operations, to government and law enforcement agencies, to your family members, and to certain other persons or entities. In certain circumstances, the Fund will only use or disclose your health information pursuant to your written authorization. In other cases authorization is not needed. The details of the Fund's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with certain rights related to your health information. Specifically, you have the right to:

- inspect and/or copy your health information;
- request that your health information be amended;
- request an accounting of certain disclosures of your health information;
- request certain restrictions related to the use and disclosure of your health information;
- request to receive your health information through confidential communications; and
- file a complaint with the Fund or the Secretary of the Department of Health and Human Services if you believe that your that privacy rights have been violated.

These rights and how you may exercise them are detailed below.

Changes in the Fund's Privacy Practices

The Fund reserves its right to change its privacy practices and revise this Notice as described below.

Contact Information

If you have any questions or concerns about the Fund's privacy practices, or about this Notice, or if you wish to obtain additional information about the Fund's privacy practices, please contact:

HIPAA Privacy Officer
Steelworkers Health and Welfare Fund
5 Gateway Center, 7th Floor
Pittsburgh, PA 15222
Phone: 412.562.2279
Fax: 412.562.2276

DETAILED NOTICE OF THE FUND'S PRIVACY POLICIES

THE FUND'S USES AND DISCLOSURES

Except as described in this section, as provided for by federal privacy law, or as you have otherwise authorized, the Fund uses and discloses your health information only for the administration of the Fund and the processing of your health claims.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

1. **For Treatment.** While the Fund does not anticipate making disclosures “for treatment,” if necessary, the Fund may make such disclosures without your authorization. For example, the Fund may disclose your health information to a health care provider, such as a hospital or physician, to assist the provider in treating you.
2. **For Payment.** The Fund may use and disclose your health information so that claims for health care treatment, services and supplies that you receive from health care providers can be paid according to the Fund’s terms. For example, the Fund may share your enrollment, eligibility, and claims information with a third party administrator so that it may process your claims. If you appeal a denial of benefits, the Fund may disclose your health information to the Board of Trustees so that the Board may decide the appeal. The Fund may also disclose your health information to health care providers to notify them whether certain medical treatment or other health benefits are covered under the Fund, and to claims auditors to review billing practices of health care providers and to verify the appropriateness of claims payment.
3. **For Health Care Operations.** The Fund may use and disclose your health information to enable it to operate efficiently and in the best interest of its participants. For example, the Fund may disclose your health information to actuaries and accountants for business planning purposes, or to attorneys who are providing legal services to the Fund.

Uses and Disclosures to Business Associates

The Fund shares health information about you with its “business associates,” which are third parties that assist the Fund in its operations. The Fund discloses information, without your authorization, to its business associates for treatment, payment and health care operations. For example, the Fund shares your health information with a third party administrator so that it may process your claims. The Fund may disclose your health information to auditors, actuaries, accountants, and attorneys as described above.

The Fund enters into agreements with its business associates to ensure that the privacy of your health information is protected.

Uses and Disclosures to the Plan Sponsor

The Fund may disclose your health information to the Plan Sponsor, which is the Fund’s Board of Trustees, for plan administration purposes, such as performing quality assurance functions and evaluating overall funding of the Fund, without your authorization. The Fund also may disclose your health information to the Plan Sponsor for purposes of hearing and deciding your claims appeals. Before any health information is disclosed to the Plan Sponsor, the Plan Sponsor will certify to the Fund that it will protect your health information and that it has amended the Fund’s plan documents to reflect its obligation to protect the privacy of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

As described below, the federal health privacy law provides for specific uses or disclosures that the Fund may make without your authorization:

1. **Required by Law.** Your health information may be used or disclosed as required by law. For example, your health information may be disclosed for judicial and administrative proceedings pursuant to court or administrative order legal process and authority; to report information related to victims of abuse, neglect, or domestic violence; and to assist law enforcement officials in their law enforcement duties.
2. **Health and Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person. Your health information also may be disclosed for public health activities, such as preventing or controlling disease, injury or disability, and to meet the reporting and tracking requirements of governmental agencies, such as the Food and Drug Administration.
3. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, security clearance activities and protection of public officials. Your health information also may be disclosed to health oversight agencies for audits, investigations, licensure and other oversight activities.
4. **Active Members of the Military and Veterans.** Your health information may be used or disclosed in order to comply with laws and regulations related to military service or veterans' affairs.
5. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation benefits.
6. **Emergency Situations.** Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster.
7. **Others Involved In Your Care.** In limited circumstances, your health information may be used or disclosed to a family member, close personal friend, or others who the Fund has verified are directly involved in your care (for example, if you are seriously injured and unable to discuss your case with the Fund). Also, upon request, the Fund may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.
8. **Personal Representatives.** Your health information may be disclosed to people that you have authorized to act on your behalf, or people who have a legal right to act on your behalf. Examples of personal representatives are parents of unemancipated minors and those who have Power of Attorney.
9. **Treatment and Health-Related Benefits Information.** The Fund and its business associates may contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you, including, for example, alternative treatment, services and medication.
10. **Research.** In certain circumstances, your health information may be used or disclosed for research purposes as long as the procedures required by law to protect the privacy of the research data are followed.
11. **Organ, Eye and Tissue Donation.** If you are an organ donor, your health information may be used or disclosed to an organ donor or procurement organization to facilitate an organ or tissue donation or transplantation.
12. **Deceased Individuals.** The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Fund and its business associates do not use your health information for fundraising or marketing purposes.

Any Other Uses and Disclosures Require Your Express Authorization

Uses and disclosures of your health information *other than* those described above will be made only with your express written authorization. You may revoke your authorization to use or disclose your health information in writing. If you do so, the Fund will not use or disclose your health information as authorized by the revoked authorization, except to the extent that the Fund already has relied on your authorization. Once your health information has been disclosed pursuant to your authorization, the federal privacy law protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your knowledge or authorization.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Fund creates, collects and maintains.

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. Your health record includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records.

To inspect and copy your health record, submit a written request to the HIPAA Privacy Officer. The Fund may deny your request in certain very limited circumstances. In some of these circumstances, you may have the denial reviewed.

Right to Request That Your Health Information Be Amended

You have the right to request that your health information be amended if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed written request to the HIPAA Privacy Officer. This request must provide the reason(s) that support your request. The Fund may deny your request if it is not in writing, it does not provide a reason in support of the request, or if you have asked to amend information that:

- was not created by or for the Fund, unless you provide the Fund with information that the person or entity that created the information is no longer available to make the amendment;
- is not part of the health information maintained by or for the Fund;
- is not part of the health record information that you would be permitted to inspect and copy; or
- is accurate and complete.

The Fund will notify you in writing as to whether it accepts or denies your request for an amendment to your health information. If the Fund denies your request, it will explain how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Fund to others, except that disclosures for treatment, payment or health care operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The accounting covers up to six years prior to the date of your request (but will not include disclosures made before April 14, 2003). If you want an accounting that covers a time period of fewer than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit a written request to the HIPAA Privacy Officer. The first accounting that you request within a twelve month period will be free. For additional accountings in a twelve month period, you will be charged for the cost of providing the accounting, but the Fund will notify you of the

cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Fund uses or discloses about you to carry out treatment, payment or health care operations, or to someone who is involved in your care or the payment for your care, such as a family member or friend. The Fund is not required to agree to your request for such restrictions, and the Fund may terminate any agreement it has made to the restrictions you requested.

To request restrictions, submit a written request to the HIPAA Privacy Officer that explains what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Fund will notify you in writing as to whether it agrees to your request for restrictions, and when it terminates agreement to any restriction.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that your health information be communicated to you in confidence by alternative means or to an alternative location. For example, you can ask that you be contacted only at work or by mail, or that you be provided with access to your health information at a specific location.

To request communications by alternative means or at an alternative location, submit a written request to the HIPAA Privacy Officer. Your written request should state the reason for your request, and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of the information by non-confidential communications could endanger you. Reasonable requests will be accommodated to the extent possible and you will be notified appropriately.

Right to Complain

You have the right to complain to the Fund and to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Fund, submit a written complaint to the HIPAA Privacy Officer listed above. You will not be penalized in any way for filing a complaint.

CHANGES IN THE FUND'S PRIVACY POLICIES

The Fund reserves the right to change its privacy practices and make the new practices effective for all health information that it created or received before the effective date of the change and that it may receive in the future.

EFFECTIVE DATE

This Notice is effective as of April 14, 2003, and will remain in effect unless and until the Fund publishes a revised Notice.

SECTION VII: STATEMENT OF ERISA RIGHTS

As a Participant, you have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). These include the right to:

- examine, without charge, all Fund documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Fund with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. You may look at these documents at the Fund Office or other locations such as union halls and worksites where at least fifty (50) participants work;
- obtain, upon written request to the Board of Trustees, copies of documents governing the operation of the Fund, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Fund may make a reasonable charge for the copies;
- receive a summary of the Fund's annual financial report. The Board of Trustees is required by law to provide each participant with a copy of the summary annual report every year; and
- continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Fund 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 Fund on the rules governing your COBRA continuation rights.

In addition to creating rights for Fund Participants, ERISA requires the people who operate the Fund to meet certain responsibilities. These people, called "fiduciaries," must act solely in the interest of you and other Participants and beneficiaries, and must act prudently in performing their duties.

Although the Fund does not guarantee your employment, no one may fire you or discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA (not your Employer, the Union or any other person).

If your claim for a benefit is denied, 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:

- If you ask the Board of Trustees for a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such case, the court may require the Board of Trustees to provide the materials and pay you a fine of up to \$110 a day until you receive them, unless the materials were not sent because of reasons beyond the Board of Trustees' control.
- If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or Federal court.
- If you disagree with the Board of Trustees' (or its delegate's) decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

- If Plan fiduciaries ever misuse the Fund's money or 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 the court costs and legal fees – possibly the person you have sued if your case is successful. However, if you lose the case, the court may order you to pay court costs and legal fees – if the court finds your claim is frivolous, for example.

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

OTHER FACTS ABOUT THE FUND

General Information: The Fund is a multiemployer welfare fund established by the Union. The Board of Trustees is the Plan Administrator within the meaning of, and for the purposes of, section 16(A) of ERISA, and has been designated as the agent for the service of legal process. Its address is the same as that of the Fund Office. Service of process may also be made on any individual Trustee.

Type of Administration: Self-administration, contract administration and insurer administration.

Other Information: The Plan Number assigned to the Fund is 501. The Board of Trustees' Employer Identification Number is 23-1317409. The Fund's fiscal records are maintained on the basis of a Plan Year that is the 12-month period beginning each January 1 and ending each December 31.

SECTION VIII: TRUSTEES

Thomas Conway, Chairman

International Vice President – Administration
United Steelworkers
Five Gateway Center
Pittsburgh, PA 15222

Dennis Fleming, Trustee

Staff Representative
USW District 10
1945 Lincoln Highway
North Versailles, PA 15137

Ann Flener, Trustee

Assistant Director, Organizing Department
United Steelworkers
Five Gateway Center
Pittsburgh, PA 15222

William Harriday, Trustee

Staff Representative
USW District 8
1818 Todds Lane, Unit E
Hampton, VA 23666

Arthur Kroll, Assistant Director

USW District 2
13233 Hancock Drive
Taylor, MI 48180

Raymond Jastrzab, Trustee

Staff Representative
USW District 10
519 Somerset Street, Suite 1
Johnstown, PA 15901-264

Eugene Nicklow, President

USW Local Union 2632
519 Somerset Street, Suite 4
Johnstown, PA 15901

