

VI. MEDICAL BENEFITS

A. SCHEDULE OF MEDICAL BENEFITS

Eligibility Waiting Period: Coverage takes effect on the first of the month following the date of eligibility as provided herein.

Benefit Period: January 1 through December 31

The Plan has contracted with HealthLink to obtain discounts from network providers for covered charges. This discount network is HealthLink Open Access III. Under this arrangement, benefit levels vary with the network status of the provider **you** use. The highest benefits are paid when **you** use Health Maintenance Organization (HMO) providers, while slightly lower benefits are paid when **you** use Preferred Provider Organization (PPO) providers. Benefits are further reduced when **you** use **non-network providers**.

Although the highest level of benefits in the HealthLink Open Access III program is payable when using “**HMO**” **Providers**, it is not a traditional HMO. **You** do not have to select a primary care **physician** or obtain referrals to see specialists. **You** do not have to choose to be in the HMO or PPO; **you** are free to use any provider at any time subject to the Plan’s exclusions and limitations.

In addition to its contract with HealthLink, the Plan has a contract with the PHCS Managed Care’s PPO for geographic areas not serviced by HealthLink. Benefits for covered services obtained from PHCS network providers will be paid at the PPO benefit level shown in the Schedule of Benefits.

The "Out of Area" benefit level will be payable when there are no **HMO or PPO providers** available within 50 miles to provide necessary treatment.

A separate listing of **HMO** and **PPO providers** will be provided to **you** automatically without charge, however in order to ensure that **you** obtain the most up-to-date information available about participating **physicians, hospitals** and other health care providers, **you** should contact HealthLink or PHCS at the telephone number listed on your medical identification card or search network providers on HealthLink’s website (www.healthlink.com), which includes a link to PHCS.

Covered services obtained from a **non-network provider** will be covered at the PPO benefit level, if treatment is for an **accident** or **emergency** medical condition as defined in this Plan and care cannot be obtained from an **HMO** or **PPO provider** without jeopardizing the patient’s health. Ambulance transportation will be paid based on the network participation of the facility to which the patient is transported.

Plan Annual Medical Maximum: \$1,000,000 per individual

The above maximum is applicable to all benefits payable during a calendar year for expenses listed as covered medical expenses under this Plan.

The following Plan benefits will vary depending on whether services are obtained from an HMO, PPO or non-network provider.

Cash Deductible (Per Calendar Year):

	<u>HMO</u>	<u>PPO</u>	<u>Non- Network</u>	<u>Out-of- Area</u>
<i>Individual</i>	\$150	\$150	\$200	\$200
<i>Family</i>	\$300	\$300	\$400	\$400

The cash **deductible** is the amount of covered expenses which must be **incurred** in a calendar year before benefits are payable for covered medical expenses **incurred** during the remainder of that year. It is in excess of any amount paid under any other benefit provisions of this Plan.

Although covered expenses for each individual are subject to the **deductible**, the total amount required for **you** and all of **your dependents** combined will not be more than the "family" amount shown above.

Note: Expenses applied to the **deductible** for any provider category will also be applied to the **deductible** requirement for the other provider categories. For example: If **you** incur expenses of \$100 from a **PPO Provider**, your remaining **deductible** will be \$50 for **HMO** and **PPO Providers** and \$100 for **non-network** and **out-of-area providers**. If **you** incur \$200 in expenses from a **non-network provider**, your **deductible** will be satisfied for all other providers.

Out-of-Pocket Maximum (Per Calendar Year Including the Deductible):

	<u>HMO</u>	<u>PPO</u>	<u>Non- Network</u>	<u>Out-of- Area</u>
<i>Individual</i>	\$1,000	\$2,000	Unlimited	\$2,000
<i>Family</i>	\$1,000	\$2,000	Unlimited	\$2,000

Once **you** and/or **your dependents** have paid the **out-of-pocket maximum** amount shown above during any calendar year, the Plan will pay eligible covered expenses **incurred** during the remainder of that calendar year at 100%.

The **out-of-pocket maximum** does not include expenses **incurred** due to reduction to the UCR payment level or other non-covered expenses.

Note: No matter which provider **you** or **your dependents** use (HMO, PPO, Non-Network or Out of Area), all **co-payments** and **co-insurance** will be used to satisfy any out-of-pocket limit (e.g., HMO **co-payments** will apply towards the PPO **out of pocket maximum**).

1. Medical Benefits Payable

The following table is a summary of medical benefits payable under the Plan. For a complete description of covered medical expenses, as well as any exclusions and limitations, please refer to the "Covered Medical Expenses" and "Medical Exclusions and Limitations" sections. All services are subject to the applicable calendar year **deductible**, unless otherwise noted.

Services	Limitations	Benefit Percentage			
		<u>HMO</u>	<u>PPO</u>	<u>Non-Network</u>	<u>Out of Area</u>
Hospital Services:					
Inpatient	Semi-Private Room	100%	90%	70%	90%
Outpatient		100% after \$25 Co-pay	90% after \$25 Co-pay	Not Covered	90% after \$25 Co-pay
Emergency Room*		100% after \$50 Co-pay (waived if admitted)	90% after \$50 Co-pay (waived if admitted)	70% after \$50 Co-pay (waived if admitted)	90% after \$50 Co-pay (waived if admitted)
Physician Services:					
Office Visits		100% after \$10 Co-pay	100% after \$20 Co-pay	70%	90%
Other Physician Services*		100%*	90%*	70%*	90%*
Wellness Benefit: --Routine Physical Exam --Breast and Pelvic Exam --Routine Mammogram --Immunizations --Well Child Care --PSA Test for Men over age 40		100% No Deductible	100% No Deductible	Not Covered	100% No Deductible
Chiropractic Care	\$1,000 Calendar Year Maximum	100%	90%	70%	90%
Private Duty Nursing		100%	90%	70%	90%
Skilled Nursing Facility	Semi-Private Room	100%	90%	70%	90%
Rehabilitation Facility	Semi-Private Room	100%	90%	70%	90%
Physical Therapy		100%	90%	70%	90%
Occupational Therapy		100%	90%	70%	90%
Speech Therapy		100%	90%	70%	90%

Services	Limitations	Benefit Percentage			
		<u>HMO</u>	<u>PPO</u>	<u>Non-Network</u>	<u>Out of Area</u>
Home Health Care		100%	90%	70%	90%
Hospice Care	Semi-Private Room	100%	90%	70%	90%
Treatment of Infertility	\$5,000 Maximum per Calendar Year; \$10,000 Maximum Lifetime	100%	90%	70%	90%
TMJ Treatment	\$1,500 Maximum per Calendar Year	100%	90%	70%	70%
Mental Health & Substance Abuse Treatment:					
Inpatient		100%	90%	70%	90%
Outpatient		100% after \$10 Co-pay	90% after \$25 Co-pay	70%	90%
Vision Benefit	\$150 Maximum Benefit per Calendar Year;	100% No Deductible	100% No Deductible	100% No Deductible	100% No Deductible
All Other Covered Expenses (except as otherwise noted)		100%	90%	70%	90%

***Charges made by an emergency room physician, radiologist, pathologist or anesthesiologist will be paid based on the network participation of the facility at which services are received.**

2. Prescription Drug Schedule of Benefits

	Benefit_Percentage	
	Participating Pharmacy	Nonparticipating Pharmacy
Retail Pharmacy <i>Up to 34-day supply</i>		
Per Generic Drug	100% after \$5.00 Co-pay	70% after \$5.00 Co-pay
Per Brand Name Drug	100% after \$15.00 Co-pay	70% after \$15.00 Co-pay
Mail Order <i>Up to 100-day supply</i>		
Per Generic Drug	100% after \$10.00 Co-pay	N/A
Per Brand Name Drug	100% after \$30.00 Co-pay	N/A

B. MEDICAL BENEFIT PAYMENT PROVISIONS

1. Covered Expenses

Covered/Eligible medical expenses means the expenses **incurred** by **you** or **your dependents** for the **hospital** or other medical services listed below, which meet the following criteria:

- a. The expenses must be for a service or supply prescribed by a **physician**.
- b. The expenses must be for a service or supply which is **medically necessary** in connection with the diagnosis or therapeutic treatment of an **injury** or **illness**. In determining whether a service or supply, what portion of a service or supply or what length of **hospital** confinement or amount of treatment is included in this provision, a service or supply must be ordered by a **physician** and be commonly and customarily recognized by the **physician's** profession in the United States as safe, effective, appropriate and reasonably necessary treatment of the diagnosed **injury** or **illness**. It must not be educational, **experimental** or **investigatory** in nature, or provided primarily for research. It must neither be for **custodial care** nor **maintenance care**. An independent **physician** or review organization may be enlisted to assist the **Plan Administrator** in reaching such a determination.
- c. The expenses must not exceed: (1) the **usual, customary and reasonable fee (UCR)** for such treatment, or (2) in the case of **HMO** or **PPO Providers**, the discounted fee negotiated between the **Managed Care Organization** and the Provider.
- d. The expenses must not be excluded under the Exclusions and Limitations sections of this Plan.

2. Managed Care Benefits

The Plan from time to time enters into special arrangements with one or more **Managed Care Organizations (MCOs)** which provide favorable pricing for the Plan and/or favorable **deductibles** and **co-payment** limits for **you** and **your dependents** when **you** use **HMO** or **PPO** network providers. Benefits payable by the Plan for covered expenses for services, treatments, or drugs and medicines provided by an **HMO** or **PPO provider** will be determined in accordance with the agreement then in effect with such **MCO** as set forth in the Schedule of Benefits.

3. Allocation and Apportionment of Benefits

The Plan reserves the right to allocate the **deductible** amount to any eligible charges and to apportion the benefits to **you** and any assignees. Such allocation and apportionment will be conclusive and will be binding upon **you** and all assignees.

4. Lifetime and Annual Maximum Amounts

The maximum amounts payable for all covered expenses **incurred** during your or **your dependent's lifetime** and per calendar year are noted in the Schedule of Benefits. The word "**Lifetime**" as used herein, means the duration of participation in this Plan. The word "annual" refers to a calendar year.

5. Common Accident

If two or more persons in the same family are injured in a common **accident**, the cash **deductible** applicable in the calendar year of the **accident** will be limited to a single **deductible** amount for that calendar year for covered expenses related to that **accident** which are **incurred** by all family members.

6. Cost Containment Features

a) Voluntary Predetermination Program

This Plan does not require precertification prior to receiving services or supplies. The Plan, however, does provide a voluntary predetermination program as to the **medical necessity** of certain services and supplies. If **you** participate in this program and the service or supply is determined to be **medically necessary** then, when your claim is submitted after the services are rendered, the claim will not be denied on that basis, assuming the facts are as represented during the predetermination process. (A request for predetermination will not be considered a claim. To file a claim under this Plan, there must be a written request for payment for services or supplies that have already been provided to **you**. See the "Claim Procedures" section for details on how to file a claim.)

There is no penalty simply because a predetermination of **medical necessity** is not requested or obtained. However, when a claim is submitted after the services or supplies have been received, the Plan will review the claim in accordance with the plan requirement that services and supplies be **medically necessary** in connection with the diagnosis or therapeutic treatment of an **injury** or **illness** (see requirements for Covered Expenses on page 43). Thus, if **you** receive services or supplies without a predetermination, **you** risk discovering after receiving such services or supplies, that they are not considered necessary and are, therefore, not covered under the Plan. **Unless you use voluntary predetermination, medical necessity will be decided when the claim is filed after the service is provided. In such a case, you may be entirely responsible for the cost of any non-covered services or supplies.**

If **you** wish to participate in the Voluntary Predetermination Program, follow the instructions below.

To determine the patient's eligibility and whether the service or supply is covered or excluded under the terms of the Plan, contact the **claim administrator**. Neither HealthLink nor any medical consultant has the

authority to determine whether the service or supply is covered or to what extent benefits are payable. Even after a determination of **medical necessity**, the **claim administrator** will review the claim for eligibility and coverage only after it is submitted after services are rendered. Thus, a claim for **medically necessary** services could be denied on other grounds.

Neither HealthLink, the Plan, nor any independent medical consultant will make any decisions regarding your medical treatment or the receipt of health care services. **You** should make all final decisions about your medical care after consultation with your **physician**.

(1) Voluntary Predetermination of Surgical Procedures, Other Outpatient Procedures and Home Health Care

To predetermine whether any scheduled surgical procedure, other outpatient procedure or home health care service is considered **medically necessary**, call J.W. Terrill toll-free at 800-467-5982. J.W. Terrill may then refer your case to HealthLink or contact an independent medical consultant to determine the **medical necessity** of the initial treatment program and continued care. **You** and your **physician** will be notified of the decision.

(2) Precertification of Mental Health and Substance Abuse Treatment

Although not required to do so, **you** are strongly encouraged to precertify **mental health treatment** and **substance abuse** treatment through People Resources (800-765-9124). Any treatment that is not precertified before services are received will be retroactively reviewed for **medical necessity**, and any services found not to be **medically necessary** will not be covered under the Plan.

(3) Hospital Admissions

Before **you** or a family member enters a **hospital** for non-emergency inpatient admission, your **physician** may contact HealthLink toll-free at (877) 284-0102 to initiate the review process. HealthLink and/or an independent medical consultant will determine the **medical necessity** of the hospitalization and **you** and your **physician** will be notified of the decision.

(4) Voluntary Concurrent Review

If **you** elected voluntary predetermination of **hospital** admission, HealthLink's **nurses** will perform periodic reviews of your medical progress and will check with your **physician** and **hospital**. If HealthLink approves the continued stay as **medically necessary**, your claim will not be denied on that basis.

In the event of an **emergency** admission, **you** or your **physician** may contact HealthLink within 48 hours following the admission to participate in the voluntary concurrent review program.

If **you** elected voluntary predetermination of a mental health or **substance abuse treatment** service, People Resources, Inc. offers Voluntary Concurrent Review of your condition.

(5) Review of Voluntary Predetermination

If **you** or your **physician** disagree with a predetermination that a hospitalization, length of stay, surgery or outpatient procedure is not **medically necessary**, **you** or your **physician** may contact HealthLink toll-free at (877) 284-0102 or J.W. Terrill at 800-467-5982 to review the situation. In the case of a mental health or substance abuse predetermination, you or your physician may contact People Resources at 800-765-9124. Because the Plan does not recognize a claim until after the services are rendered, there is no appeal procedure. If **you** disagree with the predetermination decision, **you** may obtain the services and, when the claim is submitted after the services have been performed, the claim will be reviewed by the Plan without deference to the negative predetermination decision made by HealthLink, People Resources or another consultant.

b) Second Surgical Opinion (Voluntary)

Benefits will be payable at 100% of the **usual, customary and reasonable fee** for all charges relating to a second surgical opinion for any **elective surgical procedures**, including related expenses. The **deductible** will not apply. The second opinion must be rendered by a board-certified surgeon, actively in practice within the specialty associated with the condition being treated, who is not professionally or financially associated with the **physician** or the surgeon who rendered the first surgical opinion. The surgeon who gives the second surgical opinion may not perform the surgery. If the second opinion disagrees with the first, a third opinion will also be payable at 100%, provided the opinion is obtained before the procedure is performed. The conditions that apply to a second surgical opinion also apply to the third surgical opinion.

If special tests or procedures are required to render a second opinion, the second opinion **physician** must obtain approval from the **claim administrator** before ordering or performing the tests or procedures.

c) Case Management/Alternate Treatment under Case Management

In cases where the patient's condition is expected to be or is of a serious nature, the **Plan Administrator** may arrange for review and/or case management services from a professional qualified to perform such services. The **Plan Administrator** will have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of patient care.

Fees for case management services are medical benefits and will be reimbursed at 100% and will not be subject to the calendar year **deductible** or annual maximum. Treatment services and supplies recommended by the case manager

are subject to all other Plan provisions (**deductible, co-insurance** and annual maximum). Benefits for alternative treatment will be determined on the merits of each individual case, and any benefits for care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to **you** or **your dependents** or with respect to other persons who participate in the Plan.

d) High-Risk Pregnancy Benefit

If **you** or **your dependent** is pregnant and **you** comply with all of the following requirements and deliver a well baby, the Plan will pay \$200 of the baby's **hospital** charges at the rate of 100%.

- **You/your dependent** must notify the **claim administrator** within two (2) weeks following a positive pregnancy test.
- **You/your dependent** must have the obstetrician complete the high-risk pregnancy questionnaire furnished by the **claim administrator**.
- **You/your dependent** must not smoke during the pregnancy.
- If the pregnancy is classified as “high risk,” **you/your dependent** must comply with all the recommendations of the case management organization selected by the Trustees.

C. COVERED MEDICAL EXPENSES

To the extent that the following charges meet all of the elements of “Covered Expenses” set forth beginning on page 43, benefits will be payable for these charges as shown in the Schedule of Benefits.

1. Ambulance Transportation

The Plan will pay for **ambulance transportation** to the **hospital** where treatment is given or between medical facilities when **medically necessary**. Benefits will be paid based on the network participation level of the facility to which the patient is transported.

2. Anesthesia

The Plan will pay for charges for **anesthesia services** for surgical procedures covered by the Plan.

3. Case Management/Medical Review Fees

The Plan will pay fees for case management and medical consultant review services as a medical benefit under the Plan. Those charges will be paid at 100% and will not be subject to the calendar year **deductible** nor will the amount paid for these services be applied towards your individual annual maximum. Charges for medical treatment services and supplies recommended by the case manager will continue to be subject to regular Plan benefits (**deductible, co-insurance** and annual maximum).

4. Chiropractic Care

The Plan will pay charges for chiropractic treatment including tests and therapy ordered by a chiropractor, limited to \$1,000 per calendar year for each covered individual.

5. Dental Services

The Plan will pay charges for dental services rendered by a **physician** for treatment of **injury** to natural teeth if:

- The **injury** is caused by an **accident**;
- All treatment is rendered within six (6) months of the **accident**; and
- All treatment is rendered while covered by this Plan.

Hospitalization and/or Anesthesia in Connection with Non-Covered Dental Services

Medically necessary anesthesia and hospital expenses rendered in connection with dental services for a child under nine years of age are covered, however, hospitalization and/or anesthesia for custodial purposes or patient convenience are not covered.

6. Diagnostic Testing

The Plan will pay for the following diagnostic testing:

- X-rays, CT scans, MRIs, microscopic tests, diagnostic tests and monitoring, and laboratory tests.
- Electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by **physicians** throughout the United States.

7. Durable Medical Equipment

The Plan will pay for:

- rental of a wheelchair, **hospital** bed, ventilator, or other **durable medical equipment** required for therapeutic use, up to the **usual, customary and reasonable** purchase price, or
- the purchase of this equipment if economically justified.

8. Foot Orthotics

The Plan will pay charges for foot orthotics prescribed by a **physician** and their repair when **medically necessary**, subject to the following limits:

- Covered charges are limited to \$200 per foot.
- Foot orthotics are limited to one pair per year.
- Foot orthotics are not covered for corns, calluses and hammertoes.

9. Home Health Care

The Plan will pay charges made by a **home health care agency** for care in accordance with a **home health care plan**. Such expenses include:

- Part-time or intermittent nursing care by a registered **nurse** (R.N.), a licensed practical **nurse** (L.P.N.), a vocational **nurse**, or public health **nurse** who is under the direct supervision of a registered **nurse**.
- Home health aides.
- Medical supplies, drugs and medicines prescribed by a **physician**, and laboratory services provided by or on behalf of a **hospital**, but only to the extent that they would have been covered under this Plan if **you** or **your dependent** had remained in the **hospital**.

Specifically excluded from coverage under the home health care benefit are the following:

- Services and supplies not included in the **home health care plan**.
- Services of a person who ordinarily resides in the home of **you** or **your dependent**, or is a **close relative** of **you** or **your dependent**.
- Services of any social worker.

- Transportation services.
- Housekeeping **and custodial care**, other than those custodial services required to maintain proper hygiene, patient feeding and other patient needs that cannot be performed by the patient.
- Charges for services in excess the maximum shown on the Schedule of Benefits.

“Home health care visit” means a visit by a member of a home health care team. Each such visit that lasts for a period of four (4) hours or less is treated as one home health care visit. If the visit exceeds four (4) hours, each period of four (4) hours is treated as one visit and any part of a four (4) hour period that remains is treated as one home health care visit.

10. Hospice

The Plan will pay charges relating to **hospice** care provided that the person has a life expectancy of six months or less. **Hospice** care may extend beyond the initial six months if the attending **physician** certifies that the person is still terminally ill. Covered **hospice** expenses are limited to:

- Room and board for confinement in a **hospice**.
- Charges for ancillary services and supplies furnished by the **hospice** while the patient is confined therein, including rental of **durable medical equipment** which is used solely for treating an **injury** or **illness**.
- Medical supplies prescribed by the attending **physician**, but only to the extent such items are necessary for management of the terminal condition;
- **Physician** services and/or nursing care by registered **nurse**, a licensed practical **nurse**, or a licensed vocational **nurse** (L.V.N.).
- Home health aide services.
- Home care charges for home care furnished by a **hospital** or **home health care agency**, under the direction of a **hospice**, including **custodial care** if it is provided during a regular visit by a registered **nurse**, a licensed practical **nurse**, or a home health aide.
- Medical social services by licensed or trained social workers, psychologists, or counselors.
- Nutrition services provided by a licensed dietitian.
- Respite care.
- Bereavement counseling. Bereavement counseling is a supportive service provided by the **hospice** team to the deceased’s immediate

family after the death of such terminally ill person. Such visits are to assist the family in adjusting to the death. Benefits will be payable up to the bereavement care maximum shown in the Schedule of Benefits provided:

- On the date immediately before his death, the terminally ill person was in a **hospice** care program and covered under the Plan; and
- Charges for such services are **incurred** within twelve (12) months of the terminally ill person's death.

11. Hospital Services

The Plan will pay for the following charges by a **hospital**:

a) *Inpatient*

- Room and board expenses **incurred** for a ward or semi-private room or 90% of the most common private room rate for a **hospital** that does not have semi-private accommodations.
- Expenses **incurred** for confinement in an intensive care unit, cardiac care unit or burn unit or isolation unit when the patient's condition would be compromised or caretakers and visitors would be subject to health care risks without certain care management rendered during isolation.
- Miscellaneous **hospital** services and supplies.
- Charges for a well newborn baby for nursery room and board, and for professional service required for the healthy newborn. Eligible expenses will also include charges for pediatric services and circumcision.
- Benefits will be payable from the date of birth until the earliest of: the date the mother is released; the date the **child** is released; or the **child's** fifth day of age. (Newborns of **dependent children** are not covered, except as provided under the Plan's "High Risk Pregnancy" provision.)

b) *Outpatient*

- Charges for services and supplies by a **hospital** or **ambulatory surgical center** for a surgical operation or services or supplies provided in connection with the surgery within 48 hours after the surgery is performed, or
- Charges by a **hospital** or minor emergency medical clinic for **emergency** treatment for injuries provided within 48 hours after the **accident**.
- Charges by a hospital for other medically necessary non-surgical procedures.

12. Infertility Treatment

The Plan will pay charges for **you** or your spouse related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer or low tubal ovum transfer. Benefits are limited to \$5,000 per calendar year and \$10,000 **lifetime** for all medical infertility treatment.

13. Kidney Dialysis

Charges for **kidney dialysis** treatment will be payable on the same basis as any other **illness** or **injury** covered under the Plan.

14. Maternity Care

The Plan will pay charges for the following:

- Maternity care, on the same basis as any **illness** covered under this Plan. Benefits for **dependent children** are limited to one pregnancy per daughter.

The Plan will not restrict benefits for any **hospital** stay in connection with childbirth for the mother or newborn **child**, following a vaginal delivery, to less than 48 hours, or to less than 96 hours in the case of a cesarean section. The mother's or newborn's provider, after consulting with the mother, may discharge the mother or her newborn before the expiration of the 48-hour (or 96-hour as applicable) period.

- Charges for elective abortions, including medications prescribed to bring about abortion, for **you** or **your dependents**. Benefits are limited to one abortion per **dependent** daughter.

15. Mental Health and Substance Abuse Treatment

The Plan will pay charges for **medically necessary mental health treatment** and **substance abuse** treatment.

16. Miscellaneous Covered Expenses

The Plan will also pay for the following charges:

- Injectable drugs and for syringes and needles for home administration other than for insulin.
- Radiation therapy or treatment, and **chemotherapy**.
- Processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.
- Oxygen and other gases and their administration.

- Hyper alimentation or Total Parenteral Nutrition (TPN) for persons recovering from or preparing for surgery.
- Dressings, sutures, casts, splints, trusses, crutches, braces, or other necessary medical supplies, with the exception of dental braces or corrective shoes.
- Vaccines for Human Papilloma Virus (HPV) when administered in accordance with generally accepted medical guidelines by an **HMO** or **PPO provider**.
- Birth control devices (diaphragms and IUDs)

17. Occupational Therapy

The Plan will pay charges for the treatment and services rendered by a registered occupational therapist under the direct supervision of a **physician** in a home setting or at a facility or institution whose primary purpose is to provide medical care for an **illness** or **injury**, or at a free standing, outpatient facility, up to the maximum shown in the Schedule of Benefits.

18. Organ Transplants

The Plan will pay organ transplant expenses **incurred** in conjunction with the transplant of a human organ or tissue in accordance with the rules described in the table below.

<u><i>Situation</i></u>	<u><i>Coverage</i></u>
The recipient is covered under this Plan and receives the organ from a cadaver.	The recipient's expenses, including the charge for the organ, are covered.
The recipient is covered under this Plan and receives the organ from a bank.	The recipient's expenses, including the charge for the organ, are covered.
The recipient and the donor are both covered under this Plan.	The expenses of both are covered under the donor's claim. Eligible donor's charges are limited to \$20,000.
The recipient is covered under this Plan and the donor's expenses are not covered under any other plan.	The expenses of both are covered under the recipient's claim. Eligible donor's charges are limited to \$20,000.
The recipient is covered under this Plan and the donor's expenses are covered under another plan.	Only the recipient's expenses are covered.

Situation

The donor is covered under this Plan but the recipient is not.

Coverage

The expenses of neither are covered unless the recipient is a parent, sibling or **child** of the donor, in which case only the donor's expenses are covered.

Organ Transplant Expenses include: pre-transplant testing and consultation; all services and supplies required for the transplant procedure; postoperative care in the **hospital** (inpatient or outpatient); extended care in a facility or at home; pharmaceuticals and their administration, including but not limited to high-dose **chemotherapy** or anti-rejection drugs; **durable medical equipment**; and, to the extent specified above, the donor's expenses.

The Trustees of the Plan strongly encourage covered individuals to contact the **claim administrator** before undergoing any inpatient procedure, including an organ transplant procedure. If **you** do not contact the **claim administrator**, **you** run the risk of discovering that the procedure is not covered by the Plan, after expenses have been **incurred**.

19. Physical Therapy

The Plan will pay charges for the treatment or services rendered by a physical therapist under direct supervision of a **physician** in a home setting or a facility or institution whose primary purpose is to provide medical care for an **illness** or **injury**, or at a free standing duly licensed outpatient therapy facility, up to the maximum shown in the Schedule of Benefits. Treatment received from a **physical therapy** assistant will be covered if it is administered in a **hospital**, under the direction of a **physician** and under the supervision of a registered physical therapist.

20. Physician Assistant/ Nurse Practitioner Services

The following services rendered by a **physician assistant** or nurse practitioner are covered, provided: (a) the **physician assistant** or nurse practitioner is employed by a licensed **physician** or clinic, which also employs supervisory **physician**; (b) services are rendered under the supervision of the employing **physician** or clinic; and (c) the employing **physician** or clinic and **physician assistant** or nurse practitioner are **HMO or PPO providers**. Drugs, medications, devices, therapies or services rendered, furnished or prescribed by a **physician assistant** or nurse practitioner must be rendered, furnished or prescribed pursuant to a **supervision agreement** that is specific to the clinical condition diagnosed and treated by the supervising **physician**.

a) *Covered Physician Assistant/ Nurse Practitioner Services:*

- Taking patient histories.
- Performing physical examinations.
- Performing or assisting in the performance of routine laboratory and patient screening procedures.
- Performing routine therapeutic procedures.
- Recording diagnostic impressions and evaluating situations calling for attention of a **physician** to institute treatment procedures.
- Instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by the employing **physician**.
- Assisting the supervising **physician** in institutional settings, including review of treatment plans, ordering tests and diagnostic laboratory and radiological procedures and ordering of therapies, using procedures reviewed and approved by the employing **physician**.
- Assisting at surgery.

b) *Physician Assistant/ Nurse Practitioner Services Not Covered by the Plan:*

- Services or tasks prohibited by law.
- Services not rendered under the supervision of a **physician**.
- Services that the **physician assistant** or nurse practitioner has not adequately been trained or is not proficient to perform.
- Abortion.
- Lenses, prisms and contact lenses for the aid, relief or correction of vision or the measurement of visual power or acuity.
- Administration or monitoring of general or regional block anesthesia during diagnostic tests, surgery or obstetrical procedures.
- Expenses for surgical assistance to **physicians** who participate in the Plan's HMO or PPO are covered only when billed by the HMO or PPO **physician**. No expenses for surgical assistance billed by a **hospital** or surgical facility or an independent **physician assistant**, nurse practitioner or **non-network provider** are covered.

c) *Level of Reimbursement for Physician Assistant/ Nurse Practitioner Services:*

Covered expenses for services rendered by a **physician assistant** or nurse practitioner are limited to 85% of the amount that would have been allowed as a covered expense had a **physician** rendered the services. Such covered expenses are subject to the Plan's applicable HMO or PPO reimbursement levels and subject to all of the Plan's limitations and exclusions.

21. Physician Services

The Plan will pay charges for the services of a legally qualified **physician** for medical care and/or surgical treatments, including office, home visits, **hospital** inpatient care, **hospital** outpatient visits/exams, inpatient **mental health** and **substance abuse** treatment, clinical care, and surgical opinion consultations.

22. Private Duty Nursing

The Plan will pay fees of registered **nurses** (R.N.'s) or licensed practical **nurses** (L.P.N.'s) for private duty nursing.

23. Prosthetics

The Plan will pay for artificial limbs, eyes or larynx, to replace lost limbs or eyes and for the replacement of such prosthetics if necessary because of physiological changes.

24. Rehabilitation Facility

The Plan will pay charges **incurred** for confinement in a **rehabilitation facility**. Room and board charges are limited to semi-private room charge.

25. Skilled Nursing Facility

The Plan will pay charges **incurred** for confinement in a **skilled nursing facility**. Room and board charges are limited to semi-private room rate.

26. Smoking Cessation Treatment

The Plan will pay charges for auriculotherapy for smoking cessation treatment for **you** and your spouse, upon prior notice to the **claim administrator**. Covered expenses for auriculotherapy are not subject to the calendar year **deductible** and will be payable at 100% up to the maximum smoking cessation benefit for each eligible individual of \$250 per calendar year and \$500 **lifetime**. The calendar year and **lifetime** maximum benefits apply to charges for all smoking cessation treatment, including auriculotherapy and medications covered under the Plan's prescription drug benefits. **No benefits will be payable for auriculotherapy if the claim administrator is not notified prior to receiving treatment.**

27. Specialty Drugs

The Plan will pay charges for certain specialty drugs dispensed or administered by a **physician** or **hospital**, however, benefits are limited to the lowest available cost to the Plan from a specialty pharmacy (as determined by case management). The Plan will pay 100% of the cost of the drug from the specialty pharmacy.

Specialty drugs are drugs that are used in treating serious **illnesses** and conditions, such as cancer, hemophilia, growth hormone deficiency and rheumatoid arthritis, and are sometimes administered by injection or infusion. These drugs can be very expensive. If your doctor or **hospital** proposes to directly administer or dispense any drug to **you**, for example by an injection or

infusion in the office or **hospital**, please contact the **claim administrator**, J.W. Terrill, at (314) 594-2755 or 800-467-5982. The **claim administrator** can tell **you** whether the drug is a specialty drug subject to this limitation. If it is, case management will direct **you** to a specialty pharmacy where **you** can obtain the drug at a lower cost to **you** and to the Plan.

A complete list of the medications to which this limit currently applies is available from J.W. Terrill. The list, however, is subject to change at any time, and **you** should check with J.W. Terrill every time your **physician** or **hospital** proposes a new specialty drug.

28. Speech Therapy

The Plan will pay fees of a licensed speech therapist under direct supervision of a **physician** for restorative **speech therapy** for speech loss or impairment due to an **illness** or **injury**, or due to surgery performed on account of an **illness** or **injury**, other than a functional nervous disorder, up to the maximum shown on the Schedule of Benefits. Speech Therapy is not covered for educational purposes or developmental delays.

29. Surgical Procedures

The Plan will pay charges for the following:

- **Medically Necessary** surgical and endoscopic procedures
- Oral surgical procedures as follows:
 - Excision of impacted teeth;
 - Open or closed reduction of a fracture or dislocation of the jaw.
- **Cosmetic** procedures or treatment rendered for **cosmetic** purposes only in the following situations:
 - The treatment of an **accidental** bodily **injury**, provided the treatment is rendered within six months after the **injury**;
 - The surgical correction of a congenital anomaly in a **dependent child**; or
 - Reconstructive surgery following surgery due to an **illness**, including the following mastectomy-related expenses:
 - All stages of reconstruction of the breast on which the mastectomy was performed,
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance,
 - Prostheses, and
 - Treatment of physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of the lymph nodes).
- Services for voluntary sterilization, such as vasectomy or tubal ligation, for **you** and **your dependent** spouse.

- Routine colonoscopies when performed by an **HMO** or **PPO provider** in accordance with generally accepted medical age and frequency guidelines.

30. Temporomandibular Joint Syndrome (TMJ) Treatment

The Plan will pay charges for Temporomandibular Joint Syndrome (TMJ) Treatment and related care including x-rays, injections, surgery and appliances, payable to the maximum shown in the Schedule of Benefits.

31. Vision Benefits

The Plan will pay charges for the following vision services, up to the limit shown in the Schedule of Benefits:

- Routine eye examinations performed by a licensed optometrist or ophthalmologist.
- Eyeglass lenses and frames or contact lenses prescribed by a licensed optometrist or ophthalmologist.

32. Wellness Care

The Plan will pay benefits for the following wellness care obtained from an **HMO** or **PPO provider** (or from an **out-of-area** provider, if the covered person resides outside of the network service area). The Plan's "wellness benefit" covers the following services:

- Physical examinations which may include tests such as complete blood count, urinalysis, VDRL, tine test, screener, pap test, stool culture and sigmoidoscopy;
- Breast and Pelvic exams;
- Routine mammograms;
- Inoculations and immunizations;
- **Physician's** charges for well-child care;
- Annual PSA test for men age 40 and over.

Exceptions:

- Services such as electrocardiogram or chest x-rays, are not covered unless symptoms warrant the tests.
- Wellness benefits are not provided for examinations or inoculations required for employment, insurance or licensing, camp or marriage.
- **Services rendered by non-network providers are not covered.**

D. MEDICAL EXCLUSIONS AND LIMITATIONS

No benefits of any kind will be provided under this Plan to your **eligible dependent** spouse or **child** who has medical benefits provided by or through his or her own employer or union, or in the case of a **child**, his or her parent's employer or union, unless the type of benefits provided by or through that employer or union, when that plan of the other employer or union is primary under this Plan's coordination of benefits rules, are not affected by the fact that the **dependent** is also covered under this Plan.

The following exclusions and limitations apply to expenses **incurred** by **you** and **your dependents**:

1. Charges **incurred** prior to the effective date of coverage under the Plan, or after coverage is terminated;
2. Charges for any services covered under a "terminal liability," "extension of benefits" or similar provision of a previous medical benefit plan that was replaced by this Plan until such a time as the extended coverage has terminated;
3. Charges **incurred** as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country;
4. Injuries arising out of or in the course of any occupation for wage or profit, or an **illness** for which **you** or **your dependent** is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law;
5. **Hospital** confinement, medical or surgical services or other treatment furnished or paid for by or on behalf of the United States, or any state, province or other political subdivision, unless there is an unconditional requirement to pay such charges whether or not there is insurance or medical benefits;
6. Charges **incurred** for which **you** or **your dependents** are not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage;
7. **Injuries** or **illnesses** resulting from the covered individual's driving under the influence of alcohol in excess of the legal limit or an illegal controlled substance;
8. **Injuries** or **illnesses** resulting from the covered individual's conduct that constitutes a felony under applicable law, whether or not charged or convicted;

9. Charges **incurred** in connection with any intentionally self-inflicted **injury** or **illness**, unless such **injury** or **illness** results from a medical condition (including both physical and mental conditions);
10. Charges **incurred** for services or supplies which constitute personal comfort or beautification items, television or telephone use, or charges in connection with **custodial care**, education or training, or expenses actually **incurred** by other persons;
11. Charges **incurred** for **cosmetic** procedures or in connection with care or treatment rendered for **cosmetic** purposes except as specifically provided under “Covered Medical Expenses”;
12. Charges **incurred** in connection with services and supplies which are not necessary for treatment of an active **illness** or **injury** or are in excess of **usual, customary and reasonable fee**, or are not recommended and approved by a **physician**;
13. Charges for services, supplies or treatment not commonly and customarily recognized throughout the **physician’s** profession or by the American Medical Association as generally accepted and **medically necessary** for the diagnosis and/or treatment of an active **illness** or **injury**; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value;
14. Charges for services rendered to **you** or **your dependents** by a **physician**, **nurse** or licensed therapist, who is a **close relative** or resides in the same household;
15. Charges **incurred** outside the United States if **you** or **your dependents** traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies;
16. Charges for inpatient confinement primarily for x-rays, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an active **illness** or **injury**, unless otherwise provided under any wellness benefits covered under this Plan;
17. Charges for **physicians’** fees for any treatment that is not rendered by or provided under the supervision of a **physician**;
18. Charges **incurred** in connection with eye refractions, the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices unless specifically included in the Medical Expenses section. This exclusion

will not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery, nor does it apply to the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure;

19. Charges **incurred** for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes; however, benefits will be payable for charges **incurred** for treatment required because of **accidental injury** to natural teeth, or for any oral surgical procedure listed under this Plan's covered expenses. Such expenses must be **incurred** within six (6) months of the date of **accident**. This exception will not in any event be deemed to include charges for treatment for the repair or replacement of a denture;
20. Charges for **experimental** procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States;
21. Charges for callus or corn paring or excision; toenail trimming; any manipulative procedure for weak or fallen arches, flat or pronated foot, or foot strain, except for open cutting operations; orthopedic shoes or other devices for support of the feet (except covered expenses for foot orthotics as shown on page 49);
22. Any surgical procedure for the correction of a visual refractive problem, including radial keratotomy and LASIK;
23. Any inpatient **hospital** charges **incurred** on a Friday, Saturday, or Sunday if admission is made on one of these days, unless surgery is performed within 24 hours of the admission or the admission is necessitated by an **emergency**;
24. Charges for **maintenance care**. Unless specifically mentioned otherwise, the Plan does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function;
25. Charges for weight reduction. This exclusion does not apply to **medically necessary** treatment of morbid obesity (a body weight that is 100% over the weight given in standard tables); endogenous obesity (caused within the body) including but not limited to metabolic factors such as hyperinsular, hyperinterrenal, hypogonad, hypothyroidism, hypercholesterolemia, and obesity due to hypothalamic lesions; or exogenous obesity (caused by overeating) if: a diagnosis of morbid obesity is given and a separate medical condition is present which is aggravated by obesity (e.g., high blood pressure, chronic back conditions, varicose veins, etc.). It is recommended that **you** use the Plan's voluntary predetermination program for weight reduction treatments to ensure **medical necessity**;

26. Charges **incurred** as a result of or in connection with more than one pregnancy of a **dependent** daughter;
27. Charges for Prescription Drugs, except as for specialty drugs as described under “Covered Medical Expenses” on pages 56-57. (For a description of the Fund’s prescription drug benefits, refer to the "Prescription Drug Benefits" section, which begins on page 65);
28. Vocational rehabilitation services;
29. Charges related to sex transformation procedures and/or treatments;
30. Charges for services not covered by **Medicare** because **you** and your health provider have entered into a “private contract” (under the Balanced Budget Act of 1997 or otherwise) which exempts the services from **Medicare**, its regulations and its price controls. When **Medicare** is the primary payer, only those expenses covered by **Medicare** are covered under this Plan;
31. Charges for services and supplies provided by a non-network **ambulatory surgery center** or rendered by a **non-network provider** in a non-network **ambulatory surgery center** or by a **non-network provider** for those services listed under the Plan’s wellness care provision;
32. Genetic testing and counseling, except that genetic testing and counseling to assist in the diagnosis or treatment of an existing **illness** will be covered;
33. Prophylactic surgery or treatment, except that prophylactic surgery or treatment to assist in the treatment of an existing illness or to prevent or lessen the likelihood of recurrence of an existing **illness** will be covered.
34. **Preexisting Condition Exclusion**

a) Preexisting Conditions

Expenses **incurred** in connection with a **preexisting condition** are excluded from coverage under the Plan until the end of the **preexisting condition exclusion period**. The **preexisting condition** exclusion applies to the following persons who are age 19 or older:

- persons who have never had creditable coverage;
- persons who have previously had creditable coverage for less than twelve (12) consecutive months;
- persons who have been without creditable coverage for 63 days or more upon enrollment in the Plan.

b) Creditable Coverage

Upon the Plan's receipt of a **Certificate of Creditable Coverage**, credit will be given toward the **Preexisting Condition Exclusion Period** equal to the number of months in which a **preexisting condition** exclusion is satisfied under any one of the following plans:

- an insured or self-insured group health plan
- health insurance coverage
- **Medicare**
- Medicaid and Title X
- Indian Health Service Program
- state high risk pools
- public health plans
- Peace Corps benefits
- State Children's Health Insurance Programs (S-CHIP)

The credit does not apply to coverage periods preceding lapses in coverage of 63 days or more. Benefit **waiting periods** do not count as lapses in coverage.

You and your dependents have the right to request a Certificate of Creditable Coverage from any prior plan. This Plan will provide assistance in obtaining a certificate upon request. There are also other ways that **you** can show **you** have creditable coverage. Please contact the Fund Office if **you** need help demonstrating creditable coverage.

c) Preexisting Condition Definitions

Preexisting Condition: A condition is preexisting if medical advice, diagnosis, care or treatment for the condition was recommended or received from an individual licensed or similarly authorized to provide medical service within the six (6) month period ending on the person's **enrollment date** in the Plan. Pregnancy and genetic information are not considered **preexisting conditions**.

Enrollment Date: The first day of coverage or, if there is a **waiting (or probationary) period**, the first day of the **waiting period**. The **enrollment date** (not the coverage effective date, if different) is used to mark the end of a break in coverage, and is used to start the six month "look back" period for determining whether a condition is preexisting.

Preexisting Condition Exclusion Period: A period of 12 months (365 days) from the **enrollment date**.

Waiting or Probationary Period: The time between the date of employment and the date coverage is effective. This period does not count

as creditable coverage but does count toward satisfying the **preexisting condition exclusion period**.

Certificate of Creditable Coverage: A form showing the length of time a person had Creditable Coverage with a carrier or plan, and indicating the **waiting period** starting date and the coverage effective and termination dates without a break of 63 days or more.

d) Exceptions to the Preexisting Condition Exclusion

The exclusion of coverage due to this **preexisting condition** exclusion shall be modified as follows:

1. This paragraph shall not apply to restrict your or **your dependent's** coverage under the Plan if coverage was terminated during a period of **FMLA leave** and then reinstated after the conclusion of the **FMLA leave**.
2. For those persons covered on the effective date of this Plan and covered on the immediately preceding day under the policy or plan this Plan replaced, whether such replaced policy or plan was written by an insurer or under a similar but not insured plan:
 - a. If **you** or **your dependents** incur expenses which would be eligible for payment hereunder except for the **preexisting condition** provision and such expense would have been eligible for payment under the replaced policy or plan had that policy or plan been continued in force rather than replaced by this Plan, this Plan will pay the lesser of the amount payable for such expenses under:
 - i) The replaced policy or plan, and
 - ii) This Plan disregarding the **preexisting condition** provision.
 - b. No item of expense **incurred** before the effective date of this Plan shall be payable under this Plan.
 - c. In no event shall the term "this Plan" be construed to include the policy replaced.