

**LABORERS' DISTRICT COUNCIL
BUILDING AND CONSTRUCTION
HEALTH & WELFARE FUND**

**SUMMARY PLAN DESCRIPTION
AND
BENEFIT PLAN DOCUMENT**

Revised September 2006

Building and Construction Health & Welfare Fund

**LABORERS' DISTRICT COUNCIL
BUILDING AND CONSTRUCTION
HEALTH AND WELFARE FUND**

FUND OFFICE

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SECTION I
INTRODUCTION

**LABORERS' DISTRICT COUNCIL
BUILDING AND CONSTRUCTION
HEALTH AND WELFARE FUND**

Dear Participant:

May 2002

A general description of the benefits available from your Health and Welfare Plan, and the eligibility rules, are contained in this booklet. We urge you to keep this document in a safe place for future reference. Take the time to read the material in this booklet. These are valuable benefits that are of critical importance to you and your family. Every effort has been made to describe your benefit coverage in easy-to-understand language. Nevertheless, health coverage is a complicated subject matter that often times does not lend itself to easily described terms and concepts. For that reason, the Fund Office is staffed with highly trained personnel, well versed in the Fund's Plans, and ready to answer your questions and benefit inquiries.

This booklet contains the latest changes and clarifications approved by your Board of Trustees. From time-to-time, when benefit changes are made, you will receive a new page, or pages, reflecting the effective date of benefit changes, to be inserted into this Booklet in its proper location.

We hope you will agree that these are valuable benefits to be used wisely. Get the most value out of each of your Fund dollars because they are vitally important to you and the members of your family.

Sincerely,

THE BOARD OF TRUSTEES

LABORERS' DISTRICT COUNCIL
BUILDING AND CONSTRUCTION
HEALTH AND WELFARE FUND

La informacion contenida en este libretin es para su propio beneficio.

En caso do que usted no lea ingles y necesite de ayuda para comprender los beneficios de nuestro programa, por favor, llame al nuestro administrador, Alan Parham, por telefono: (215) 236-6700. El podra darle toda la asistencia posible.

Los Regentes

NOTICE OF IMPORTANCE TO PARTICIPANTS

Eligibility for benefits provided under the Plan is based on hours worked for which the Employer is required to report and pay contributions to the Fund in accordance with the collective bargaining agreement.

Failure on the part of an Employer to correctly report all hours worked and pay contributions can result in “loss of coverage.”

Similarly, benefit eligibility may be adversely affected if you work for an Employer who has not signed the collective bargaining agreement, even though such Employer may have reported work hours and made payment of contributions.

Remember that the benefits are provided for you and your eligible dependents.

You are urged to take the following steps to protect your benefits:

1. Keep a Personal Record of the correct name and address of each Employer for whom you may work, the Job Name and Site Location.
2. Know when your pay period begins and ends. Keep a record of hours actually worked on a day by day basis. Total your hours at the end of each payroll period.
3. Keep pay check stubs, envelopes and other wage statements that may be provided to you by your Employer.
4. Periodically check with your Fund Office to determine Work Hours reported for you.
5. Make sure that each Employer for whom you may work has signed the collective bargaining agreement. This information may be obtained from the Business Manager and/or Field Representatives of your Local Union.

In summary, you become a participant in the Fund if you work for Employers who are signatory to the collective bargaining agreement covering work in the commercial, industrial, institutional and/or home building construction fields, requiring such Employers to report hours worked and pay contributions on your behalf.

INTRODUCTION

This booklet contains a summary, in English, of your plan rights and benefits.

If you have any difficulty understanding any part of this document, contact the Fund Office at any time during regular business hours (9 a.m. to 5 p.m.), Monday through Friday and the office personnel will provide you with assistance as may be required.

PRIVACY POLICY

The Trustees have adopted policies and procedures designed to protect your personal information from unauthorized use or disclosure. Towards that end:

Plan Administration has implemented physical, electronic and procedural safeguards to maintain the confidentiality and integrity of the personal information in our possession and to guard against unauthorized access. These measures include, among other things, procedures for controlling access to participants' files, building security programs and information technology security measures such as the use of passwords, encryption and firewalls, plus virus and use detection software.

Fund Administration continues to access new technology as it becomes available and to upgrade our physical and electronic security systems as appropriate.

The Fund's policy is to permit Fund employees and professionals employed by the Fund to access your personal information only if they have a legitimate purpose for using such information, such as administering the Plan, reviewing and analyzing claims and claim denial appeals, and/or providing plan benefits to participants. No personal information is used for any employment related decision or action.

Information Subject to the Policy

The Fund collects information about you to help us provide Plan benefits to you and your eligible dependents, and to fulfill legal and regulatory requirements. Fund Administration considers all information about you in our possession to be personal information, even if you cease to be a Plan Participant. The personal information we collect may include, among other things:

- Identifying information, such as your name, age, address, phone number and social security number.
- Employment information.
- Personal health information.

Typically we collect this information on applications and other forms you complete, through conversations you may have with our administrative staff and health care professionals, and from reports and data provided to us by health service care providers.

Sharing Information within the Fund Administrative Office

Fund Administration shares personal information about you among our staff primarily to enable us to provide you with Plan benefits. It is also used to assure compliance with applicable laws and regulations.

Sharing Information with Health Care Providers and Other Plan Professionals

We share personal information about you, as required or permitted by law, with third parties, such as service providers who assist us in the day-to-day operations of our Plan. These third parties include: health care professionals, printing companies, software providers and plan professionals. Our policy is to require third-party service providers to enter into confidentiality agreements with us, prohibiting them from using any personal information they obtain for any purposes other than those for which they were retained or as required by law. We may also disclose information about you, when necessary or required, in legal and arbitration proceedings and to government agencies.

We understand that you may be especially concerned about the privacy of your personal health information. We do not sell or rent your personal health information to anyone or disclose it to others for marketing purposes. Except as you have otherwise authorized, we only use and share personal health information for the administration of the Plan and processing claims. The same holds true for any other personal information contained in, or obtained in order to process your claims.

Reviewing your Personal Information

If you would like a report on the personal information about you in our possession (other than information collected in connection with or in anticipation of a claim or legal proceeding), you may write us describing the information you would like. If requested, we will also identify in the report any third parties with which we normally share information about you. If you believe that any information we have about you is incorrect or incomplete, you may advise us of any corrections, amendments or deletions which you believe should be made. To obtain a report, please write to Alan Parham, Fund Administrator, 665 North Broad Street, 2nd Floor, Philadelphia, PA 19123. We may charge you a reasonable fee to cover the costs of providing this information to you.

Changes to Our Privacy Policy

The Trustees may make changes to our privacy policy in the future. The Fund will not make any change affecting you without first sending you a revised privacy policy describing the change.

REPORTING AND FILING OF CLAIMS

Whenever you or your dependents incur Dental, Life, AD & D or Disability expenses for which coverage is provided in the Schedule of Benefits, you should immediately contact the Fund Office by phone, letter or in person and request claim forms. Written notice of claims must be given to the Plan Administrator within **120** days after a covered loss starts or as soon as reasonably possible.

For your medical program, refer to Section 7 of the Personal Choice Section of this booklet for information on "Claim Filing" and to the back of your identification card for pre-certification and other Personal Choice phone numbers.

Also refer to your NPA-NVA identification card for information on your prescription and vision programs.

Eligibility for any payment of benefits is subject to the terms of the Plan. An early determination of need for confinement is binding on the Plan unless the Plan is misled by the information given to it. If a member believes the Plan failed to follow the procedure described above, he/she must submit a written request to the Trustees for a review of the decision.

IMPORTANT

Completed claim forms and/or bills should be submitted within one hundred and twenty (120) days after the commencement of a claim. The failure of a member to file a claim in a timely fashion as defined in this paragraph may result in denial of that claim by the Plan Providers.

In case of fraud or attempted fraud upon the Fund, the Board of Trustees may, in its discretion, cease benefit payments until the matter is resolved. In the case where a Covered Person has received funds by reason of a fraud, such Covered Person and or his/her dependents shall not be entitled to further payment of benefits until the amount of monies improperly and fraudulently received from the Fund shall have been repaid to the Fund.

DENIAL OF CLAIMS AND RIGHT TO APPEAL

If you are denied benefits under the Plan, the Trustees shall advise you of the reason for such denial with specific reference to the Plan provision upon which the denial is based and shall describe any additional material or information necessary for the claim to be honored (if applicable). The timing of notice of the claim denial determination, and an explanation of your right to appeal such decisions are set forth in detail in the Claim Review Procedures section of this booklet.

SECTION II
ELIGIBILITY

ELIGIBILITY

WHO IS ELIGIBLE

In order to become eligible to receive benefits from the Laborers' District Council Building and Construction Health and Welfare Plan, an individual must meet the following requirements:

- (1) Be a member of the "Eligible Class";
- (2) Work the required number of hours in a "Work Period"; and
- (3) Properly complete, sign and return the Census and Enrollment Card to the Health and Welfare Fund Office.

A person who fulfills all of the foregoing requirements is hereinafter referred to as a "Covered Person," from the beginning of and during the Benefit Period for which he fulfills these requirements.

No medical examination is required.

ELIGIBLE CLASS

The Eligible Class consists of the following categories of persons:

- (1) Persons who work or who are available for work on jobs in which they are represented for collective bargaining purposes by the Laborers' District Council of the Metropolitan Area of Philadelphia and Vicinity, or one of its affiliated Local Unions under a Collective Bargaining Agreement requiring the Employer to make contributions to this Fund, and for whom contributions have been so made.
- (2) Persons employed by the Laborers' District Council of the Metropolitan Area of Philadelphia and Vicinity, or its affiliated Local Union, including persons serving as elected or appointed officers of such Council, Local Union or Funds, or jointly administered employee benefit funds sponsored by Laborers' District Council.

COVERED EMPLOYMENT

In order for a person in the Eligible Class to be covered by the Plan, he/she must have credit for the required number of "Hours Worked" in covered employment.

In applying the Hours Worked requirement to determine whether a person of the Eligible Class is entitled to receive benefits, two (2) calendar periods shall be used:

- (1) The period in which the person must obtain credit for the qualifying number of Hours Worked is called the "Work Period."
- (2) The period during which he/she is eligible for benefits because he/she has credits for the required number of Hours Worked is called the "Benefit Period."

To receive benefits within the Benefit Periods, the person must have worked the required number of hours for which the Employer has reported to his/her credit and paid contributions to the Fund in the Work Periods preceding the Benefit Periods.

EXPLANATION OF "HOURS WORKED" CREDIT

A person will be given credit for an "Hour Worked" for each hour in Covered Employment for which he/she is entitled to be paid for actual work or for reporting time, and for each hour to which he/she is entitled to credit pursuant to the terms of any reciprocal agreement to which the Fund is a party.

ELIGIBILITY REQUIREMENTS FOR BENEFIT COVERAGE

If you work at least 300 hours for a Participating Employer in the Commercial and/or Home Building Construction Fields, and such Employer has made payment of contributions to the Fund, on your behalf, for said number of "Hours Worked" during a Work Period, as shown below, then you shall qualify as a "Covered Person" and you and your eligible Dependents will be entitled to "Benefits" provided under this Plan, as a result of Non-Occupational Accidental bodily injuries or a sickness not due to Occupational Disease which occurs during the corresponding Benefit Period, as shown below, subject to the limitations and provisions pertaining to such benefits as described in this booklet.

WORK PERIOD

November, December, January,
February, March, April

May, June, July August,
September, October

BENEFIT PERIOD

May, June, July, August,
September, October

November, December, January,
February, March, April

HOURS BANK

“Hours Bank” means the Individual Account established for each person in the Eligible Class to credit “Hours Worked” during each “Work Period” in excess of 450 hours. The required amount of hours in a WORK PERIOD, to become eligible for a BENEFIT PERIOD, is 300 hours. Bank Hours are those hours worked in excess of 450 hours in each WORK PERIOD.

The purpose of the “Hours Bank” is to permit a person of the “Eligible Class” to accumulate credited “Hours Worked” as a safety factor against loss of benefits due to failure to work the required 300 hours during a WORK PERIOD to maintain eligibility for the next BENEFIT PERIOD.

Note: A person’s “Hours Bank” shall never exceed a maximum of 900 hours. When a person’s “Hours Bank” is reduced (because of withdrawing banked hours to gain eligibility), that person shall be entitled to credit for any hours in excess of 450 hours (up to a maximum of 600 hours) earned in a current WORK PERIOD. The excess hours will be used to replenish the “Hours Bank” up to the allowable limit of 900 hours. However, any person who had accumulated more than 900 hours in their “Hours Bank” prior to October 31, 1982, shall retain any such excess in their “Hours Bank.”

During any WORK PERIOD in which a person fails to have reported to his/her credit the required 300 hours, the required hours for eligibility, for the BENEFIT PERIOD immediately following such WORK PERIOD will automatically be withdrawn from such person’s “Hours Bank.” Whenever the “Hours Bank” is used, 450 hours are required to establish eligibility.

“Credited Hours” on deposit in a person’s “Hours Bank” shall become “Null and Void” upon such person’s:

- (1) ceasing to be a Member of the Eligible Class;
- (2) retirement (except as provided below); or
- (3) death, if before retirement.

However, if you are an “Approved Social Security Disabled Early Retiree” receiving a benefit under the Laborers’ District Council Construction Industry Pension Fund, you may continue to use your Hours Bank up to the maximum 900 hours or until you are no longer eligible.

WORKERS' COMPENSATION SPECIAL CREDIT HOURS AND SEPARATE HOURS BANK

A special credit of 30 hours per week up to a maximum of 26 weeks (780 hours maximum) is given to an eligible employee who is disabled as a result of an on-the-job injury or illness and is receiving benefits from Workers' Compensation. The special credit applies to each week during which Workers' Compensation benefits are paid. This special credit may accumulate over more than one WORK PERIOD. The special credit hours cease when Workers' Compensation benefits cease but in no case will the special credit exceed 26 weeks (780 hours) for any one injury or illness.

The special credit hours earned will be deposited into a separate hours bank maintained solely for use by a member during or immediately following the time when he/she is receiving Workers' Compensation benefits.

The separate hours bank will be used only after the regular Hours Bank is exhausted. Once the regular Bank is exhausted, hours from the separate hours bank, up to 300 hours, will be applied to the next BENEFIT PERIOD.

Documentation from the Workers' Compensation Bureau, the Insurance Company paying your benefit, or a letter from your employer must be sent to the Fund stating the date of injury or illness and the length of time you were on Workers' Compensation.

You, too, are responsible to notify the Fund Office that you are receiving Workers' Compensation benefits, the date they begin and any date you return to work.

DEFINITION OF ELIGIBLE DEPENDENT

Your family is eligible for coverage (Dependent Coverage) when you are eligible for Participant Coverage. An Eligible Dependent is defined as your spouse under a legally valid existing marriage, your unmarried children for whom you are financially responsible or whose coverage is your responsibility under the terms of a valid court order (including stepchildren, children legally placed for adoption and your or your spouse's legally adopted children) until the end of the month in which they reach age 19. Dependent children will be covered for benefits up to the end of the month in which they reach age 26, or the date of graduation (whichever occurs first) if they are enrolled full-time in an accredited university or college or in a technical or specialized school.

Your wholly dependent unmarried children who are physically or mentally incapable of self-support upon attaining age 19 will continue to be covered, provided you furnish the Fund Office with proof of his/her incapacity/disability as certified by the attending physician before their coverage terminates at age 19; furthermore, the disability is subject to annual medical review.

EFFECTIVE DATE OF BENEFIT COVERAGE FOR DEPENDENTS

Each person who is a dependent of a Covered Person on the date that Covered Person becomes eligible for coverage under the Plan shall become eligible on said date for the Dependent coverages then applicable.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

TERMINATION OF COVERAGE

Coverage of a Covered Person terminates at the end of a Benefit Period if a Covered Person does not have credit for the number of hours required to make him eligible for the next Benefit Period.

Dependents shall not be eligible for benefits provided by this Plan if or when the person on whom they are dependent fails or ceases to qualify as a Covered Person. However, if the Covered Person dies, his Covered Dependents will continue to be eligible until the end of the Benefit Period in which the Covered Person's eligibility would have ceased.

ELIGIBILITY REQUIREMENTS FOR BENEFIT COVERAGE AFTER RETIREMENT

You will be eligible for Pensioner (Postretirement) benefits, as described in this booklet, if you retire from active employment at or after age 65 and are receiving a pension under the Laborers' District Council Construction Industry Pension Plan.

COBRA CONTINUATION COVERAGE

Should you and/or your Dependents become ineligible for coverage under the Fund's Plan of Benefits, you have certain rights under certain conditions, to continue your coverage under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This law became effective with respect to the Fund's Plan of Benefits for certain "qualifying events" occurring on and after July 1, 1988.

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Under this law, there are circumstances under which you can receive a temporary extension of your health care coverage at group rates. This extension applies to you and your Dependents if you and they were covered by the Fund on the day before your or their coverage ended. COBRA refers to these people as “Qualified Beneficiaries.”

A Qualified Beneficiary need not show evidence of good health in order to continue coverage. However, the Qualified Beneficiary is obligated to pay a set amount as a premium for this continuation of coverage. The premium that must be paid may be different than the contribution rate being paid by your employer. The COBRA premium rates are formulated by the Fund’s Actuary in accordance with formulas defined in the federal COBRA law. Prorated credits are given in those cases where the Employer has made some contributions on your behalf, but not enough for you to qualify for normal eligibility.

A member has the right to extend his/her coverage if the coverage ends because:

- (a) You leave employment with an employer for reasons other than gross misconduct on your part; or
- (b) You no longer meet the eligibility requirements.

Your spouse has the right to extend coverage if:

- (a) You die;
- (b) You leave employment as described above, or no longer meet the eligibility requirements;
- (c) You are divorced or separated; or
- (d) You become covered by Medicare.

Your Dependent children have the right to this extended coverage if:

- (a) You die;
- (b) You leave employment as described above, or no longer meet the eligibility requirements;
- (c) You are divorced or separated;
- (d) You become covered by Medicare; or
- (e) They are no longer considered Dependents under the provisions of the Fund’s Plan of Benefits.

A Qualified Beneficiary is able to continue his/her coverage for a period up to 18 months when benefits terminate due to a member’s reduction of work hours or termination of employment, for reasons other than gross misconduct. Qualified Beneficiaries who are eligible dependents are able to continue their coverage for a period of up to 36 months in the case of the member’s death, divorce, legal separation, Medicare entitlement or should a dependent child cease to be a dependent.

It is the responsibility of the person who will lose coverage to inform the Fund Office of a divorce, separation or loss of dependent child status. The Fund Office must be notified, in writing, within sixty (60) days after one of these events occur. If the Fund Office is not notified, then that person will not be able to elect or continue his/her coverage. If the qualifying event is divorce, a copy of the certified divorce decree must be provided along with notice. If the qualifying event is legal separation,

a copy of the separation order must be provided along with this notice. If the qualifying event is a dependent child's loss of eligibility for coverage as a dependent child, a copy of the child's birth certificate must be provided with this notice, along with a certification that the child is not a full-time student.

Once the Fund Office is notified of an event that affects the coverage of a Qualified Beneficiary, the Qualified Beneficiary will be notified that he/she has the right to choose continuation coverage. He/She then has sixty (60) days from the later of the date the notice from the Fund Office was received or the date he/she would lose coverage to let the Fund Office know that he/she wants to continue coverage. If the Qualified Beneficiary does not choose it, the right to continue the group health coverage would then end. If he/she does choose it, he/she will be offered the right to continue the same coverage he/she was receiving the day before he/she lost coverage. Each Qualified Beneficiary will have an independent legal right to elect COBRA continuation coverage. However, members may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Your coverage will extend from the date of the qualifying event until the earliest of:

- the date the 18-, 29- or 36-month period, whichever is applicable, elapses;
- the date you first become covered under another group health plan;
- the date you or your dependent(s) become entitled (covered by) to Medicare;
- the date you fail to pay the monthly charge for this coverage on time;
- the date the health plan is no longer in force, or it no longer provides benefits to a person in this category; or
- the date you submit a fraudulent claim.

If a member elects COBRA coverage and, while on COBRA coverage, has a newborn child or if a child was placed with him or her for adoption after such date, the member may elect to cover the child under COBRA coverage. Note that the cost of providing COBRA coverage to the child may increase the cost of the COBRA premium. In order to cover the child, the member must notify the Plan Administrator within 30 days of the birth or placement for adoption. (If the Administrator is not notified within 30 days, the member may be required to delay enrolling the child until the Plan's next "open enrollment" period.) Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the child will be treated as a "qualified beneficiary" with independent COBRA rights. Therefore, should another event occur which would entitle the member to elect COBRA coverage during the first 18 months from the first day the member was first covered under COBRA coverage, the child will be able to elect additional coverage. This means that if the covered employee dies, becomes divorced or eligible for Medicare or if the dependent ceases to meet the Plan's definition of "dependent," the child will be able to elect to extend coverage up to a total of 36 months of coverage from the member's initial COBRA date.

If a member elects COBRA coverage for himself/herself but his/her dependents (including his/her spouse) initially decline COBRA coverage because of other health insurance coverage, the member may, during the period of his/her COBRA coverage, be able

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to enroll his/her dependents in this Plan, provided that he/she requests enrollment within 30 days after their other coverage ends. In addition, if a member has a new dependent as a result of marriage, he/she may be able to enroll his/her new spouse, provided that he/she requests enrollment within 30 days after the marriage. Under HIPAA, such dependent enrolled during a member's COBRA coverage period is not a "qualified beneficiary" and therefore does not have independent COBRA rights.

Under COBRA, you will have to pay the applicable premium for your continuation coverage. You will have a grace period of 45 days from the date of your COBRA election to pay any retroactive premium for the period from the date COBRA coverage starts until the date you elect COBRA coverage. Thereafter, you will have a grace period of 30 days to pay any subsequent premiums.

SPECIAL RULE FOR MULTIPLE QUALIFYING EVENTS

If you elect continuation coverage following a termination of employment or reduction in hours and, during the 18-month period of continuation coverage, a second event (other than a bankruptcy proceeding) occurs that would have caused you to lose coverage under the Plan (if you had not lost coverage already), you will be given the opportunity to extend the period of continuation coverage to a total of 36 months. If you elect the continuation coverage as the spouse or dependent of a Covered Employee who experienced a termination of employment or reduction in hours and, during the continuation period the employee or former employee becomes covered by Medicare, you may be given the opportunity to extend coverage for 36 months from your initial qualifying event.

SPECIAL RULE FOR TOTALLY DISABLED QUALIFIED BENEFICIARIES

The 18-month period of continuation coverage may be extended for an additional 11 months (up to a total of 29 months), for any individual who was determined to have been disabled at the time his/her work hours were reduced or his/her employment ended. To qualify for this additional coverage, the individual must provide the Plan with notice within the initial 18-month COBRA coverage period, of Social Security's Disability determination, and must remain disabled throughout the additional coverage period. The premium cost for COBRA continuation during the additional coverage period will be approximately 50% higher.

If you have any questions about this continuation coverage, please contact the Fund Office.

CERTIFICATE OF CREDITABLE COVERAGE

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), may be important to you if you have a pre-existing condition, cease coverage under this Plan and join a new group health plan. (NOTE: This Plan does not have a pre-existing condition exclusion.)

A pre-existing condition exclusion in an insurance plan means that your new insurer can refuse to pay for conditions for which you or your family members received medical advice, diagnosis care or treatment within a certain number of months before you became covered under the new plan. HIPAA provides that if you obtain group health coverage under another plan within sixty-three (63) days of being covered under this Plan, the new group health plan may have to reduce the time during which it will not pay benefits for pre-existing conditions by the amount of time you had coverage under this Plan. You will have to present a "Certificate of Creditable Coverage" to your new health plan documenting the coverage you had under this Plan. The Plan Administrator will automatically provide you with, free of charge, a Certificate of Creditable Coverage after you cease coverage under the Plan. You may also request a Certificate of Creditable Coverage from the Plan Administrator, free of charge, before losing coverage, or up to 24 months after losing coverage. The written notice requesting a Certificate of Creditable Coverage should be mailed to:

Plan Administrator
665 North Broad Street, 2nd Floor
Philadelphia, PA 19123

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998 (the "Act"). Under the Act, group health plans that provide coverage for mastectomies must also cover reconstructive surgery and prostheses for mastectomy patients. The Act requires that a member receiving benefits for a medically necessary mastectomy may also be eligible to receive benefits for:

- Surgical reconstruction of the breast on which the mastectomy has been performed;
- Surgical reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications, including lymphedemas, associated with all stages of the mastectomy procedure.

The coverage will be provided in consultation with the attending physician and the patient and is subject to the same annual deductibles and coinsurance provisions that apply to the mastectomy itself.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Effective January 1, 1998, group health plans may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not generally prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours). The Plan is governed by this federal law.

COVERAGE DURING MILITARY LEAVE, UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Under the Uniform Services Employment and Reemployment Rights Act of 1994 ("USERRA"), any Employee who is absent from his or her position of employment by reason of service in a Uniformed Service will be entitled to elect to continue Medical, Prescription Drug, Dental and Vision coverage for himself or herself and for his or her dependents under the following circumstances:

The maximum period of coverage for the Employee and the Employee's dependents under such an election shall be the lesser of:

- the 24-month period beginning on the date on which the Employee's absence begins; or
- the day after the date on which the Employee was required to apply for or return to a position of employment in accordance with USERRA.

An Employee who elects to continue Medical, Prescription Drug, Dental and Vision coverage in accordance herewith will be required to pay the cost of coverage under the Plan, except a person on active duty for less than 31 days cannot be required to pay more than the Employee's share, if any, for the coverage. The Fund Office will advise you of your cost for coverage.

For purposes of USERRA, the “Uniformed Services” include the U.S. Armed Forces, the U.S. Army National Guard and U.S. Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the U.S. in time of war or national emergency. “Service in the Uniformed Services” means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Board of Trustees may be required by law to recognize court imposed medical child support orders. The Board must honor a “qualified medical child support order” (QMCSO) which is defined as a decree or order issued by a court that obligates the Plan to continue to provide coverage and benefits to the child during the term of the order. The Board of Trustees shall determine the validity of any medical child support order they receive. Because the procedures governing QMCSOs change periodically, if you receive such an order, contact the Fund Office immediately and we will provide you with a written explanation of the Plan’s procedure which sets forth your rights and obligations.

SECTION III
SCHEDULE OF BENEFITS

**LABORERS' DISTRICT COUNCIL
BUILDING AND CONSTRUCTION
HEALTH AND WELFARE PLAN**

SCHEDULE OF BENEFITS

MEDICAL PLAN		
COVERAGES	IN-NETWORK Referral & Pre-Certification Required¹ (Personal Choice PPO Network)	OUT-OF-NETWORK Pre-Certification Required²
PLAN YEAR MAY 1 – APRIL 30		
Deductible, Co-pay, Out-of-Pocket Maximum — Based on Plan Year not Calendar Year		
Deductibles (per plan year) In-Network Out-of-Network	None N/A	N/A \$250 Single \$500 Family
Out-of-Pocket Maximum Co-Insurance (per plan year)	N/A	\$1,000 Single \$2,000 Family
Lifetime Maximum	Unlimited	\$1,000,000
INPATIENT IN-NETWORK HOSPITAL SERVICES REFER TO PERSONAL CHOICE DIRECTORY FROM INDEPENDENCE BLUE CROSS OR CALL 1-800-ASK-BLUE OR SEE WEB SITE AT www.ibx.com		
OUT-OF-NETWORK PRE-CERTIFICATION SERVICES CALL 1-800-332-2566 ALWAYS PRESENT YOUR PERSONAL CHOICE CARD WHEN RECEIVING SERVICES		
Hospital Services Inpatient With Pre-Certification Without Pre-Certification Outpatient	100% up to 365 days N/A 100%	N/A 80% up to 70 days 80% of plan allowance (after deductible)
Emergency Room (If admitted, co-payment waived.)	100% less \$25 co-payment	100% less \$25 co-payment (not subject to deductible)
Diagnostic Services Radiology, Mammograms, Laboratory, etc.	100%	80% of plan allowance (after deductible) Pre-cert may be required for some services.

MEDICAL PLAN *(continued)*

COVERAGES	IN-NETWORK Referral & Pre-Certification Required ¹ (Personal Choice PPO Network)	OUT-OF-NETWORK Pre-Certification Required ²
Therapies Cardiac Rehab (18 visits/year) Pulmonary Rehab (12 visits/year) Physical, Occupational, Respiratory and Speech Therapy	100% less \$10 co-payment 100% less \$10 co-payment	80% of plan allowance 80% of plan allowance
Radiation, Chemotherapy and Dialysis	100%	80% of plan allowance (after deductible)
Physician Charges	100%	80% of plan allowance (after deductible)
Ambulance Services (Pre-cert required for non-emergency services.)	100% (medically necessary or medical emergency)	80% of plan allowance (after deductible)
Durable Medical Equipment (PRE-CERT REQUIRED CALL (215) 567-3694) Home Health Care Hospice Care Skilled Nursing Facility	100% 100% 100% 100%	80% of plan allowance (after deductible) 80% of plan allowance (after deductible) 80% of plan allowance (after deductible) 80% of plan allowance (after deductible)
Office Visits Pediatric Preventive Care/Diagnostic (See chart in Personal Choice Section) Pediatric Immunizations Adult Preventive Care/Diagnostic (See chart in Personal Choice Section)	100% less \$5 co-pay (after deductible) 100% 100% less \$5 co-pay	80% of plan allowance 80% of plan allowance (after deductible) 80% of plan allowance (after deductible)
Maternity (Member & Spouse only) ³ Hospital charges Physician charges OB-GYN Charges	100% 100% 100%	80% of plan allowance (after deductible) 80% of plan allowance (after deductible) 80% of plan allowance (after deductible)

EMPLOYEE ASSISTANCE PROGRAM

CALL FUND OFFICE'S CONFIDENTIAL HELP LINE 1-800-258-6376

To insure full payment of benefit, each covered person and his dependents must contact the Fund before receiving treatment for mental illness or drug and/or alcohol addiction.

Substance Abuse	All services must be referred by Employee Assistance Program.
Inpatient	100% up to 7 days per detoxification admission. 30 days per year. Maximum of twice per lifetime
Outpatient	100% up to 30 visits per Benefit Period.
Mental/Nervous	All services must be referred by Employee Assistance Program.
Inpatient	100% up to 30 days per Benefit Period. Lifetime maximum of 90 days.
Outpatient	100%, 30 full session visits; 30 additional full sessions or equivalent partial hospitalization visits per Benefit Period. Lifetime maximum 120 visits.

PRESCRIPTION DRUG PLAN

NATIONAL PRESCRIPTION ADMINISTRATORS, INC (NPA)

\$5,000 FAMILY MAXIMUM PER PLAN YEAR — NOT CALENDAR YEAR

(PLAN YEAR IS MAY 1 TO APRIL 30 EACH YEAR).

MAIL ORDER AVAILABLE THROUGH CFI.

CALL NPA (1-800-4NPA-006), CFI (1-800-233-7139)

Prescription Drug	
Retail (30 Day Supply)	
Generic	\$5 co-pay
Preferred Brand	\$10 co-pay
Non-Preferred Brand	\$15 co-pay
Mail Order (90 day supply)	
Generic	\$10 co-pay
Preferred Brand	\$20 co-pay
Non-Preferred Brand	\$30 co-pay
Annual Family Maximum (includes mail order and pharmacy prescriptions)	\$5,000
	Member will continue to benefit from the Plan's discount rates after reaching \$5,000 maximum.

Revised September 2006

DENTAL PLAN

LABORERS' BUILDING & CONSTRUCTION COMPREHENSIVE DENTAL PLAN

Contact Fidelio Insurance Company at (215) 885-2443, (800) 262-4949
or www.fideliodental.com for a List of In-Network Providers

Plan Year May 1 to April 30	\$3,500 Family Maximum Per Plan Year	
COVERAGES	IN-NETWORK Participating Dentist	OUT-OF-NETWORK Non-Participating Dentist
Diagnostic, preventive, basic services. Oral Surgery, Prosthetics, Crowns, etc.	100%	100% based on Fee Schedule
Periodontics	100%	100% based on Fee Schedule
Endodontics	100%	100% based on Fee Schedule
Orthodontics*	100%	100% based on Fee Schedule
<p><i>*Dependents age 19 or under. Annual payment maximum is \$1,500. Lifetime payment is \$2,500 and is not applied to the yearly Family Maximum.</i></p>		

VISION PLAN

NATIONAL VISION ADMINISTRATORS (NVA)

Customer Service Number 1-800-672-7723

Sponsor No. 1786

	IN-NETWORK	OUT-OF-NETWORK
Vision (Routine Eye Exam only) Exam, once every 24-month period. (Children under 19 may receive exam and lenses yearly if required due to change in vision.)	100% List of participating providers and claim forms available, call NVA 1-800-672-7723. In-network provider will accept allowance paid by Fund.	\$20 Bill should be sent to NVA.
Lenses (per pair) (In-network providers will accept the allowance as payment in full.)	100%, basic clear lenses. Extras at wholesale cost plus 25%.	\$12 Single vision \$15 Bifocal lenses \$18 Trifocal lenses
Frames	Wholesale cost less \$25; member pays balance plus 20%.	\$10
Contact Lenses (Elective Cosmetic) (Benefit limited to contacts <u>or</u> frames and lenses once in a 24-month period.)	\$60 allowance toward retail minus 25%; includes exam.	\$60, includes exam.
Contact Lenses (Medically Necessary)	\$150 (provider must obtain pre-authorization)	\$150 maximum, includes exam.
LASIK	Member cost is generally 25% less than provider's normal charge.	Not available.
Use your Medical (Personal Choice) Coverage for medical conditions of the eye.		

¹All hospital admissions, both in and out-of-network require pre-certification. In-network pre-certifications will usually be performed by the primary physician and/or the hospital.

²Pre-certification for out-of-network hospitals will be the responsibility of the member. Out-of-network, non-participating provider may balance bill for difference between the allowance and actual charges.

³Maternity does not cover dependent children.

Revised November 1, 2002

SECTION IV
MEDICAL PLAN

[PERSONAL CHOICE BOOKLET LOCATED IN THE REAR OF THE BOOK AFTER PAGE 92]

SECTION V
EMPLOYEE ASSISTANCE PROGRAM

EMPLOYEE ASSISTANCE PROGRAM

The Fund will provide benefits (see Schedule of Benefits in Section III) to any Covered Person or his Covered Dependents for assistance with the treatment of mental illness and substance abuse. This program is designed to assist Covered Persons and their Covered Dependents in obtaining the appropriate treatment for their particular condition. Payment of benefits will be in accordance with the terms of the Plan.

The way the program operates is that the Covered Person or the Covered Dependent contacts the Confidential Help Line number which is 1-800-258-6376. This initial telephone contact may be made at any time as the program is available 24 hours a day. Based on a formal evaluation, covered individuals will be referred to the appropriate treatment program. Supportive follow-up contacts will be made both during and after covered individuals have entered a treatment program.

The maximum in-hospital benefit for mental illness and substance abuse is 30 days per inpatient stay, per year, with a lifetime maximum of 90 days. The maximum outpatient treatment for mental illness and substance abuse is 30 days. The 30 inpatient days may be exchanged on a two for one basis for outpatient treatment.

In order to insure the full payment of benefits, each Covered Person and his Covered Dependents must contact the Fund Office before receiving treatment for a mental illness or drug and/or alcohol addiction.

SECTION VI
PRESCRIPTION PLAN

PRESCRIPTION PLAN

SCHEDULE OF BENEFITS

**NATIONAL PRESCRIPTION ADMINISTRATORS, INC (NPA)
\$5,000 FAMILY MAXIMUM PER PLAN YEAR — NOT CALENDAR YEAR
(PLAN YEAR IS MAY 1 TO APRIL 30 EACH YEAR).
MAIL ORDER AVAILABLE THROUGH CFI.
CALL NPA (1-800-4NPA-006), CFI (1-800-233-7139)**

Prescription Drug	
Retail (30 Day Supply)	
Generic	\$5 co-pay
Preferred Brand	\$10 co-pay
Non-Preferred Brand	\$15 co-pay
Mail Order (90 day supply)	
Generic	\$10 co-pay
Preferred Brand	\$20 co-pay
Non-Preferred Brand	\$30 co-pay
Annual Family Maximum (includes mail order and pharmacy prescriptions)	\$5,000
	Member will continue to benefit from the Plan's discount rates after reaching \$5,000 maximum.

ELIGIBILITY

See Eligibility section of this booklet.

HOW THE PRESCRIPTION PLAN WORKS

All Covered Persons and their Covered Dependents receive an employee prescription card. If any corrections are necessary on your identification card, please note the corrections and return the card to the Fund Office.

At the time the prescription is to be filled, you must present your I.D. card to the contracted pharmacist. The contracted pharmacist will then fill the prescription. This is all that is required. Remember, the card may be used only by persons covered under the program. Unauthorized or fraudulent use of your card to obtain prescription drugs results in immediate cancellation of your prescription drug benefit.

Revised September 2006

COVERED PRESCRIPTION DRUG EXPENSES

Benefits are payable for any F.D.A. approved generic drug or, in the absence of a generic equivalent, any brand name drug provided it requires compounding or is a legend drug (which may not necessarily require compounding).

MAIL ORDER PRESCRIPTION DRUGS

The Fund has contracted with CFI for Mail Order Prescriptions which will supply your prescription through the mail directly to you and/or your covered dependents. By utilizing this program, Covered Persons and their Covered Dependents will have the convenience of receiving their prescriptions through the mail and also save money. The cost for Generic Prescription Drugs is \$5.00 and Brand Name Prescription Drugs is \$10.

The Mail Order Prescription Drug program works as follows:

MAIL ORDER SERVICE PROGRAM 1-800-233-7139,
Monday through Friday from 8 A.M. to 8 P.M. or
Saturday from 8 A.M. to 4 P.M. Eastern time.

The Mail Order Service Prescription Drug Program is an expansion of your current prescription drug program. It is ideal for those of you who take prescription medication on an ongoing basis because you can now enjoy several important advantages.

- (1) Have your physician begin writing prescriptions for up to a 90-day supply of medication, plus refills. If you are presently taking medication ask your doctor for a new prescription.
- (2) Send your original prescription(s) and appropriate co-payment to CFI, using a Pre-Addressed envelope. Call 1-800-233-7139 for Mail Order envelopes.

CFI will process your order and return your medication to you via US Mail or UPS, along with re-order instructions for future prescriptions and/or refills. Although CFI fills and ships your order within 48 hours of receipt, please allow 14 days from the time you mail in your order.

Order Refills

With your original prescription medication, you will receive a notice showing the number of times it may be refilled. Simply enclose this refill notice with your co-payment for each prescription and mail to CFI in the pre-addressed order envelope (which was provided with your last mail order delivery). To avoid running out, order your refills two weeks before you need them.

There is no charge for mailing your prescription.

PRESCRIPTION DRUG LIMITATIONS AND COVERAGE

- (1) Smoking cessation patches are limited to one treatment per covered participant and dependents per lifetime.
- (2) Drugs which are lawfully obtainable without a prescription are not covered. Certain injectable drugs are covered under the Medical Plan.
- (3) Insulin, hypodermic needles, syringes and other diabetic supplies are covered.
- (4) Drugs labeled: "Caution - limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual are not covered.
- (5) Drugs and injectable insulin dispensed during hospital confinement including confinement in a rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises a facility for dispensing pharmaceuticals are not covered by your prescription plan.
- (6) Drugs dispensed due to accidental bodily injury arising out of and in the course of the insured individual's employment, or occupational disease are not covered.
- (7) Prescription drugs which may be properly received without charge under local, state or federal programs are not covered.

SECTION VII
VISION PLAN

VISION PLAN

The Fund provides vision care expense benefits for a Covered Person and his/her Covered Dependents. The benefits provided under this Plan consist of the following:

- VISION EXAMINATION: You will receive a complete analysis of the eyes and related structures, including a glaucoma test, to determine the presence of vision problems and abnormalities. Vision Examinations shall be provided once every 24 months. However, if necessary, a school age Dependent Child, up to age 19, shall be entitled to a vision examination every 12 months.
- LENSES AND FRAMES: If it is determined by the vision examination that lenses and/or frames are necessary for the proper visual health and welfare of the patient, they will be provided once every 24 months together with the professional services necessary to properly adapt them to the patient. School age Dependent Children, up to age 19, will be provided lenses once every 12 months if required.
- CONTACT LENSES: Contacts lenses are furnished under the Vision Plan in connection with the following conditions:
 - Cataract surgery;
 - Correction of extreme visual acuity problems (20/70 or less);
 - Anisometropia;
 - Keratoconus; and
 - For cosmetic purposes.
- CONTACT LENSES OR FRAMES AND LENSES: Once in a 24-month period.

HOW THE PLAN WORKS

Before making an appointment for vision care services, you should refer to the NVA information that you received from NVA regarding participating providers, or you can call NVA Customer Service at 1-800-672-7723 or access the Internet at www.E-NPA.com (after you are in NPA, go to the NVA area).

Select the Doctor of your choice from the List or call NVA Customer Service and then arrange an appointment for an examination. Present your ID card on the first visit. If you select a non-participating eye care provider, you will be responsible for 100% of the cost at the time of service. Payment will be made directly to you from NVA according to the non-participating provider reimbursement schedule. You must simply submit a copy of the itemized receipt, along with a note containing your name, Social Security number or a photocopy of your plastic identification card to NVA at the following address:

National Vision Administrators
P.O. Box 1981
East Hanover, NJ 07936-1981

REIMBURSEMENT SCHEDULE

NATIONAL VISION ADMINISTRATORS (NVA)

Customer Service Number 1-800-672-7723

Sponsor No. 1786

	IN-NETWORK	OUT-OF-NETWORK
Vision (Routine Eye Exam only) Exam, once every 24-month period. (Children under 19 may receive exam and lenses yearly if required due to change in vision.)	100% List of participating providers and claim forms available, call NVA 1-800-672-7723. In-network provider will accept allowance paid by Fund.	\$20 Bill should be sent to NVA.
Lenses (per pair) (In-network providers will accept the allowance as payment in full.)	100%, basic clear lenses. Extras at wholesale cost plus 25%.	\$12 Single vision \$15 Bifocal lenses \$18 Trifocal lenses
Frames	Wholesale cost less \$25; member pays balance plus 20%.	\$10
Contact Lenses (Elective Cosmetic) (Benefit limited to contacts <u>or</u> frames and lenses once in a 24-month period.)	\$60 allowance toward retail minus 25%; includes exam.	\$60, includes exam.
Contact Lenses (Medically Necessary)	\$150 (provider must obtain pre-authorization)	\$150 maximum, includes exam.
LASIK	Member cost is generally 25% less than provider's normal charge.	Not available.

Use your Medical (Personal Choice) Coverage for medical conditions of the eye.

LIMITATIONS

The items listed below may be provided to the patient under the plan. The plan allowance will be reimbursed by NVA with the difference billed to the eligible member.

- Photochromatic lenses.
- Tinted (other than Pink #1 and #2 gradient or fashion colors).
- No-line (seamless bifocals, plan pays coverage for bifocal allowance).
- Ultraviolet, anti-reflective or edgecote.
- Progressive/Multifocals, plan pays coverage for trifocal allowance.
- Overages: Extra charges for materials and services not provided under the plan described above will be made to eligibles on the basis of the participating provider's usual, customary and reasonable charge or the plan allowance, whichever is less, but in accordance with the following payment schedule:
 - Lenses: A maximum of the wholesale cost plus 25%.
 - Frames: The actual difference between the wholesale cost or the maximum allowance plus 20% of the difference.

SECTION VIII
DENTAL PLAN

DENTAL PLAN

SCHEDULE OF BENEFITS

\$3,500 YEARLY FAMILY MAXIMUM

Based on Plan Year May 1 to April 30

No Deductible

Contact Fidelio Insurance Company at (215) 885-2443, (800) 262-4949
or www.fideliodental.com for a List of In-Network Providers

	IN-NETWORK (Participating Dentist)	OUT-OF-NETWORK (Non-Participating Dentist)
Diagnostic Services	100%	100% based on Fee Schedule
Preventive Services	100%	100% based on Fee Schedule
Basic Services	100%	100% based on Fee Schedule
Oral Surgery	100%	100% based on Fee Schedule
Prosthetics, Crowns Inlay, Onlay, Restorations	100%	100% based on Fee Schedule
Periodontics	100%	100% based on Fee Schedule
Endodontics	100%	100% based on Fee Schedule
Orthodontics*	100%	100% based on Fee Schedule
<p><i>*Dependents age 19 or under. Annual payment maximum is \$1,500. Lifetime payment is \$2,500 and is not applied to the yearly Family Maximum.</i></p>		

Revised November 1, 2002

GENERAL INFORMATION

Your dental care program is an excellent benefit. There are no deductibles, and the program has a \$3,500 annual maximum per family. The program also has a lifetime orthodontic maximum of \$2,500. This orthodontic maximum is not included in your yearly family maximum. Orthodontic benefits are for dependents up to age 19.

A Participating dentist will accept the amount that is paid by the Plan as payment in full.

A Non-Participating dentist may charge an additional fee to the member.

You are entitled to payment up to the maximum allowed by the Plan for all covered services you receive from a dentist provided that the services are considered dentally necessary.

HOW TO USE YOUR DENTAL PLAN

To maximize your benefit, select an "In-Network" dentist. You can find an "In-Network" dentist by calling Fidelio Insurance Company between the hours of 9:00 a.m. to 5:00 p.m. For local area codes (215) and (610) call (215) 885-2443. For all other callers, call (800) 262-4949. You may also go to the Fidelio website at www.fideliodontal.com or call their automated 24 hour hotline at (215) 885-2453 or outside the (215) and (610) area code call (800) 929-0340. You may choose an "Out-of-Network" dentist, however, you may be subject to additional charges or balance billing.

USING YOUR DENTAL CARD

At the time of your dental visit, present your dental identification card. The card includes the phone number for the dentist to call for eligibility.

DENTAL PLAN LIMITATIONS/EXCLUSIONS

Anesthesia is limited to dental services only when medically necessary and administered in conjunction with oral surgery and if the anesthesia agent produces a state of unconsciousness.

Services not covered are those that do not have uniform professional endorsement as identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature.

DENTAL PLAN TERMINOLOGY

Diagnostic	Procedures necessary to evaluate existing conditions and required dental care including visits, exams, diagnosis and x-rays.
Preventive	Prophylaxis (cleaning), fluoride treatments (to age 19) and space maintainers.
Restorative	Basic Restorative - Amalgam and composite fillings. Major Restorative - Inlays, onlays, crowns are benefitted where above materials are not adequate.
Oral Surgery	Extraction and oral surgery procedures, including pre- and post-operative care. General anesthesia is covered when used in conjunction with covered oral surgical procedures (see plan limitations).
Endodontics	Procedures for pulpal therapy and root canal filling.
Periodontics	Treatment to the gums and supporting structures of the teeth.
Prosthodontics	Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures. Denture repair and relining under prosthodontics are available as separate benefits if required.
Orthodontics	Procedures for straightening teeth. A benefit for dependents up to age 19.

Revised November 1, 2002

FEE SCHEDULE

Contact Fidelio Insurance Company, 2826 Mount Carmel Drive, Glenside, PA 19038 for current fees:

(215) and (610) Area Codes call:	(215) 885-2443
All other areas call:	(800) 262-4949

**[Pages 42-46 Are Reserved.
Next Page is 47.]**

Revised November 1, 2002

SECTION IX
LIFE INSURANCE

LIFE INSURANCE

SCHEDULE OF BENEFITS

COVERAGE	BENEFIT
Life Insurance	
Covered Person	\$25,000
Spouse	\$ 6,000
Children	
14 days but less than 1 year	\$ 1,200
1 year but less than 5 years	\$ 2,400
5 years but less than 26 years	\$ 3,600
Accidental Death and Dismemberment	
Covered Person Only	\$25,000

DEATH BENEFIT

Life Insurance benefits are payable as a result of the death of a Covered Person, from any cause. The death benefit, in the amount shown in the Schedule of Benefits, will be paid to the beneficiary last designated by the Covered Person.

BENEFICIARY

The beneficiary shall be the person or persons designated by you, the Covered Person, on the census enrollment card, which is furnished by the Fund Office. A Covered Person may change his/her beneficiary, at any time, without the beneficiary's consent by contacting the Fund Office and completing a Change of Beneficiary Form. The change will become effective as of the date a signed request and/or Change of Beneficiary Form is received at the Fund Office.

FACILITY OF PAYMENT

If your beneficiary dies before you and you have failed to designate a new beneficiary at the time of your death, benefits will be payable in a single sum to the first surviving beneficiary or beneficiaries in the following order:

- (a) Your surviving spouse;
- (b) Your surviving children;
- (c) Your surviving parents;
- (d) Your estate.

Revised September 2006

DEATH BENEFITS IN THE EVENT OF TOTAL DISABILITY

If you are totally and permanently disabled prior to reaching age 60 and while you are insured, you are entitled to continuation of the life insurance benefits in force at the time of your disability. In order for this continuation to remain in force, you are required to furnish proof of total and permanent disability on the necessary claim form, provided by the Fund Office. Upon furnishing proof of your total and permanent disability within twelve (12) months after the last premium was paid on your behalf, your insurance will be extended without premium for one (1) year. If you are still totally and permanently disabled at the end of that year, or any year after that, your insurance will be extended for an additional year. In order for this extension of your insurance, you must furnish proof of your continued total and permanent disability within three (3) months prior to each anniversary date of the original proof of disability.

GENERAL PROVISIONS

- (1) Life Insurance benefits cover you on or off the job.
- (2) Refer to Your Group Life Insurance Plan booklet for more detailed information about your Life Insurance coverage.

CONVERSION PRIVILEGE

If your insurance terminated due to any of the events provided below, you may convert this insurance to an individual life insurance policy. Proof of good health is not required. You may purchase any individual nonparticipating policy offered by the Insurance Company (without double indemnity or disability riders) then customarily issued to persons of the same age for the same amounts furnished by the Fund, except term insurance. You may convert your Life Insurance if it stops for any of the following reasons:

- (1) Loss of eligibility.
- (2) Termination of employment.
- (3) Termination of Policy and your life insurance under the Policy has been in effect for at least 5 consecutive years.
- (4) Amendment of the Policy which terminates the life insurance on any class of insureds.
- (5) Amount of life insurance is reduced.

The conversion coverage will be issued subject to the following conditions:

- (1) Written application and the first premium must be sent to the life insurance provider within 31 days after termination of coverage under this Plan.
- (2) The amount of insurance will not exceed the amount in force under the policy before termination.
- (3) The conversion coverage will be at the premium rate and on the form then being made available prior to the conversion.
- (4) The effective date will be the date that the insurance provided under the Plan ceases.

DEPENDENT DEATH BENEFIT

Upon receipt of the necessary proof of death of a Covered Dependent and the completion of the required claim form, furnished by the Fund Office, a death benefit will be payable to the Covered Person. The amount of this death benefit will be equal to the amount shown in the Schedule of Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT (Occupational and Non-Occupational)

HOW BENEFITS BECOME PAYABLE

Should any of the following losses be sustained while you are insured under this Policy and if due to an accident which occurs while you are insured under the Policy, you or your beneficiary will be entitled to the following:

TABLE OF INDEMNITIES

Refer to the Schedule of Benefits

Full Amount (100%) of Insurance
for Loss of:

- Life
- Both Hands
- Both Feet
- One Hand and One Foot
- Sight of Both Eyes
- One Hand and Sight of One Eye
- One Foot and Sight of One Eye

One Half (50%) of the Full
Amount of Insurance for loss of:

- One Hand
- One Foot
- Sight of One Eye

Loss of hands and feet shall mean loss by being permanently, physically severed at or above the wrist or ankle joint, and loss of sight shall mean total and permanent loss of sight.

The total amount payable for all losses as a result of any one accident shall not exceed the Full Amount of Insurance referred to in the Schedule of Benefits.

LIMITATIONS

No benefits are payable for any loss caused wholly or partly, directly or indirectly, by any of the following:

- Suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning. Exception: Infection from a cut or wound caused by an accident.
- Riding in or descending from an aircraft as a pilot or crew member.
- Any armed conflict, whether declared as war or not, involving any country or government.
- Injury suffered while in the military service for any country or government.
- Injury which occurs when you commit or attempt to commit a felony.
- Use of any drug, narcotic or hallucinogenic agent —
 - unless prescribed by a doctor.
 - which is illegal.
 - not taken as directed by a doctor or the manufacturer.

SECTION X
DISABILITY INCOME BENEFITS

DISABILITY INCOME BENEFITS

SCHEDULE OF BENEFITS

Weekly Benefit	\$200.00
Waiting Period	
Disability due to accident	None
Disability due to illness	7 days
Maximum Benefit Period	30 weeks

DEFINITION

“Total Disability” means the complete and continuous inability of an insured employee to perform the usual and customary duties of his/her own occupation as a result of non-occupational accident or illness based upon the terms of the Plan and the facts as determined by the Plan Administrator or his delegate in his sole and absolute discretion.

“Elimination Period” means the period of time from the onset of a disability, due to an accident and/or sickness, to the time that benefit payments commence. If the disability is the result of a non-occupational accident, there is no elimination period, the benefits will commence immediately. If the disability is the result of an illness, the elimination period is 7 days from the onset of disability.

CONCURRENT DISABILITIES

Weekly Income may be payable for injury or sickness but not for both, nor for more than one of either, concurrently.

RECURRENT DISABILITIES

Separate periods of Total Disability due to the same cause or causes are considered as the same period of Total Disability. A new period of Total Disability begins:

- (1) after the insured has returned to Active Work for a period of at least two continuous weeks if the disability is due to the same cause or causes as the previous disability; or
- (2) after the insured has returned to Active Work on a full-time basis for one full day and the new disability is due to a cause or causes entirely unrelated to any previous disability.

Maximum benefit for drug and alcohol treatment is limited to one per lifetime (26 weeks).

LIMITATIONS

No benefits will be payable under the Disability Income Benefits provision for:

- (1) any period of disability during which a Covered Person is not under the direct care of a physician. It is understood that no disability will be considered as beginning more than three days prior to the first visit of or to a physician.
- (2) disability due to accidental bodily injuries arising out of and in the course of a Covered Person's employment.
- (3) disability due to occupational disease; for the purpose of the Plan, the term "occupational disease" shall mean a disease for which a Covered Person is entitled to benefits under the applicable Workers' Compensation Law, Occupational Disease Law, or similar legislation.

PAYMENT OF BENEFITS

Upon completion of the claim forms furnished by the Fund Office, the benefit will be paid weekly during the period of disability, and any balance thereof will be paid at the termination of the period for which they are payable. The amount of benefit for each day of disability for which benefits are payable shall be one-seventh of the corresponding weekly benefit amount.

NOTE

Social Security and Federal Income Tax Withholding

The first six months of Disability Income Benefit payments are subject to withholding of Social Security and Federal Income Tax. The amount withheld will be credited to your Social Security and Income Tax Account by the Federal government. At the end of the year, you will be supplied with the necessary government forms to be used with your tax records.

SECTION XI

**MEDICAL BENEFIT COVERAGE FOR ACTIVE
COVERED PERSONS AND COVERED SPOUSES
AGE 65 AND OLDER**

MEDICAL BENEFIT COVERAGE FOR ACTIVE COVERED PERSONS AND COVERED SPOUSES AGE 65 AND OLDER

The Fund must provide the same coverage to active Covered Persons and their Covered Spouses age 65 and older as it does to Covered Persons under age 65. In other words, the Plan is “Primary” (pays first) for your covered health care bills and Medicare is “Secondary.” This means that the Plan, rather than Medicare, will be paying the majority of your health care bills until you lose eligibility for benefits provided by this Plan.

As long as you are covered by this Plan as an Active Employee, regardless of your age, and you have hospitalization expenses, Medicare will only pay for the portion of the basic hospital bill that you would otherwise have to pay directly. Because of the limits on what Medicare pays, it may not always reimburse you in full for those out-of-pocket expenses.

If you are enrolled in Medicare Part B (premium payment is required), Medicare will generally pay the deductible that you otherwise have to meet for doctors’ services, as well as that part of the doctor bill that this Plan does not pay, because its coverage is limited to a specific dollar amount of the doctor’s reasonable charge. Neither this Plan nor Medicare will pay for charges above what this Plan considers to be reasonable. If you drop your Part B Medicare coverage, Medicare will not pick up any portion of the Part B expense that this Plan does not pay.

If an item is covered by both this Plan and Medicare, this Plan will pay first and Medicare may fill in any remaining charge as long as you remain eligible under both this Plan and Medicare. It is likely that there are some items covered by this Plan that Medicare does not insure, and that Medicare covers some services that this Plan does not. In those cases only, this Plan or Medicare would pay.

Should you have any questions regarding this matter or if you require assistance, please contact the Fund Office.

SECTION XII
POSTRETIREMENT BENEFITS

POSTRETIREMENT BENEFITS

ELIGIBILITY REQUIREMENTS FOR POSTRETIREMENT BENEFITS

Pensioner

An active participant (Covered Person) enrolled in the Laborers' District Council Building and Construction Health and Welfare Plan who has terminated Covered Employment on or after attaining age 65 and who retires and is receiving a retirement benefit under the Laborers' District Council Construction Industry Pension Fund is eligible for Postretirement Benefits. Such Pensioner must also have been approved by the appropriate Governmental agency for Medicare benefits (see "**Important Notice**" below).

Upon receipt of due proof at the Fund Office that a Covered Person has fulfilled all of the foregoing requirements, he shall then qualify as a Covered Pensioner and be eligible to receive the Postretirement Benefits described in this Section.

Effective Date of Coverage

You will become covered for Postretirement Benefits as of the first day of the month following the month that proof of eligibility for such benefits has been received at the Fund Office.

Dependent Spouse of Pensioner

In order for the Dependent Spouse of a Pensioner to become covered by the Plan's Postretirement Group Medicare Supplemental Program, such Spouse must be Medicare Eligible, either at age 65 or Medicare Eligible due to Social Security Disability. The Spouse must also be a resident of the United States and also approved by the appropriate Governmental agency as eligible to receive Medicare benefits (see "**Important Notice**" below).

Dependent Spouse, as used herein, shall mean "an Individual who is lawfully married to the Pensioner and who resides with such Pensioner."

Upon receipt of due proof at the Fund Office that the Dependent Spouse of a Pensioner has fulfilled all of the foregoing requirements, such Spouse shall be eligible to receive the Postretirement Benefits described in this Section.

Effective Date of Spouse's Coverage

The Spouse of a Pensioner will become covered for Postretirement Benefits as of the first day of the month following the month that proof of eligibility for such benefits has been received at the Fund Office.

In the event that the Dependent Spouse does not meet the specified age requirement at the time of the Pensioner's retirement or marries the Pensioner subsequent to his retirement, then, in such event, coverage shall become effective on the first day of the month following the month of Medicare eligibility, either at age 65 or due to Social Security Disability and upon approval for Medicare benefits by the appropriate Governmental agency, or, if later, the first day of the month following the date of marriage.

*** IMPORTANT NOTICE ***

Since the benefits provided by the Plan's Pensioners' Group Medicare Supplemental Program add to, but do not replace, the benefits provided by Medicare, it is essential that you and your Spouse enroll in Medicare, including the voluntary Supplementary Medical Insurance provided under Part B of Medicare. Otherwise, there will be a serious gap in your protection against hospital and medical expenses.

In case the current normal retirement age of 65, which is applicable in determining eligibility for Medicare Benefits, becomes changed as a result of the Social Security Act being amended, such amended normal retirement age bearing on Medicare eligibility, as may be established, shall supersede the normal retirement age with respect to eligibility for Postretirement Benefits applied herein.

Change in Family Status

Prompt written notice of any change in your family status, such as marriage, divorce or death of your spouse, if you are a Pensioner, should be sent to the Fund Office.

When sending this notice, be sure to include your full name and Social Security Number.

TERMINATION OF POSTRETIREMENT BENEFIT COVERAGES

A Pensioner's benefit coverage shall be terminated by an act of the Board of Trustees or upon the death of the Pensioner.

A Pensioner's Spouse's benefit coverage shall be terminated as follows:

- (1) By action of the Board of Trustees;
- (2) As of the date that the Pensioner ceases to be eligible;
- (3) As of the date that such individual ceases to be the Spouse of the Pensioner;
- (4) As of the last day of the month in which the death of the Pensioner occurs; or
- (5) Upon the death of the Spouse.

PENSIONERS' GROUP MEDICARE SUPPLEMENTAL PROGRAM

This Section describes a Program of Hospital, Physician and Medical Services provided by the Fund which has been designed to broaden your protection by adding to, but not duplicating, the benefits provided under Medicare. Highlights of the Group Medicare Supplemental Program are illustrated in the chart located at the end of this Section.

Continuation of Pensioner benefits is at the discretion of the Trustees and depends upon the fiscal soundness of the Health and Welfare Fund.

BENEFITS

The benefits provided by this Group Medicare Supplemental Program are subject to change and/or increase in accordance with the Medicare Program. The Fund will automatically change the benefits to conform with the Medicare Program.

Read this Section carefully so that you will understand the provisions of the Program and the benefits available to you. **You should also read your Medicare Handbook carefully so that you will understand the provisions of Medicare and the benefits available to you under Medicare.**

HOSPITAL BENEFITS (Under the Group Medicare Supplemental Program)

Inpatient Hospitalization

When you are required to enter a hospital as an inpatient and the hospitalization is covered by Medicare, the Fund will pay the following amounts which are not covered by Medicare and which you would otherwise have to pay yourself:

- (a) The initial deductible amount required for hospital charges during any one benefit period.
- (b) The Part A Hospital deductible, the coinsurance payment required under Medicare, for each day from the 61st day through the 90th day of confinement during any one benefit period.

Prolonged Confinement

If in any one benefit period your hospital confinement extends beyond the specified Medicare allowed days, to include your lifetime reserve days, the following benefit will be provided by the Program:

- (a) If your prolonged confinement exceeds the 90 days and the additional 60 lifetime reserve days are available, the Program will pay the amount not paid by Medicare plus 30 additional days not covered by the Medicare program, at the semi-private room rate.
- (b) If you have exhausted your 60 lifetime reserve days and your prolonged confinement exceeds 90 days, the Program will pay 30 additional days not covered by Medicare at the hospital's semi-private room rate and related services, except that the 30 additional days are not available for mental and nervous disorders.

Thus, with both Medicare and this Program, you are covered for up to 120 days of hospital care if you have utilized your lifetime reserve days in a prior period or up to 180 days including the lifetime reserve days available under Medicare.

The additional 30 days of hospital care under this Program are subject to the limitations set forth below:

- (a) The Program will pay benefits for room and board in an amount equal to the hospital cost or charge for ward or semi-private accommodations. If a private room is occupied, you will be required to pay the hospital the excess, if any, of its charges for the private room over the hospital's most common semi-private room rate.
- (b) The 30 days will be reduced by one day for each two days of additional post-hospital skilled nursing care for which benefits were paid under this Program.

Hospital Outpatient Services

The Program will pay the 20% co-insurance when the following services are received in the hospital's outpatient department:

- (a) Clinical laboratory procedures.
- (b) Diagnostic procedures.
- (c) Emergency services.
- (d) Surgical services.
- (e) Radiation therapy.
- (f) Outpatient physician services.
- (f) Occupational, physical and speech therapy services.
- (g) Preventive services; such as Bone Mass Measurements, Cancer Screening.

Medicare will pay 50% of Outpatient psychiatric expenses. The Program will pay 50% of Outpatient psychiatric expenses.

Post-Hospital Skilled Nursing Care

Medicare provides benefits for charges incurred in a skilled nursing facility up to a maximum of 100 days during any one benefit period, provided such care follows a hospital stay of at least three days. Medicare requires a co-payment from the 21st to the 100th day. The Program will provide this co-payment in conjunction with the Medicare program.

PHYSICIANS' SERVICES BENEFITS (Under the Group Medicare Supplemental Program)

Under Medicare the individual is required to pay the first \$100 of the total covered medical expenses which he incurs in a calendar year. Medicare pays 80% of the balance of such expenses and the Program pays the remaining 20%. If you incur expenses for the following types of physicians' services and medical services and supplies, benefits are provided under the Program, after satisfaction of the annual deductible, in an amount equal to 20% of the balance of the cost or charge for such services to the extent that they are recognized under Medicare.

Benefits are provided for the following services when performed by a physician in or out of a hospital:

- Services such as surgery, in-hospital medical care and home and office visits.
- Administration of anesthetics.

Benefits are provided for the following services performed by a physician when you are not confined in a hospital (Medicare pays 100% of the physician's cost or charge for such services when you are confined in a hospital):

- Radiation therapy
- Diagnostic X-rays
- Diagnostic laboratory services

When you are confined in a hospital or skilled nursing facility, benefits are also provided for the services of the physician in charge of your case and for the physicians' consultation services.

Physicians' Services Billed by Hospital

Medicare provides 100% reimbursement of the physician's cost or charges for radiological or pathological services performed for hospital inpatients. The Program will pay 20% of the balance of the cost or charge after the annual deductible for other services of physicians when billed by a hospital to the extent that such services are covered under Medicare.

OTHER PROVISIONS (Under the Group Medicare Supplemental Program)

Medical Services or Supplies

Benefits are provided for medical services and supplies including, but not limited to the following:

- Ambulance service.
- Prosthetic devices (other than dental), such as artificial legs, arms and eyes.
- Physical therapy services.
- Rental or purchase of durable medical equipment, such as iron lungs, oxygen tents, hospital beds, leg braces and arm braces.

SPECIAL BENEFITS (Under the Group Medicare Supplemental Program)

The Medicare Plan does not cover health care when you travel outside the United States, except for some emergency situations in Mexico and Canada. The Group Medicare Supplemental Program will cover you for emergency treatment while on vacation after a \$250 deductible. The Plan will pay 80% of charges up to a lifetime maximum of \$50,000. The Program will also pay the cost or charge for in-hospital physicians' services performed during a period of hospitalization, to the extent that such cost or charge is not reimbursed by Medicare.

EXCLUSIONS

The following services are not covered by Medicare or by the Group Medicare Supplemental Program:

- (1) Hospital or medical services for which benefits are by law furnished or required to be furnished by an employer (such as Workers' Compensation).
- (2) Hospital or medical services which are furnished by any governmental body or agency.
- (3) Services of any practitioner who is not legally licensed to practice medicine and surgery, except to the extent specifically required by law.
- (4) Services or items which are excluded under Medicare, such as:
 - (a) Acupuncture;
 - (b) Dental care;
 - (c) Cosmetic surgery;
 - (d) Custodial care (help with bathing, dressing, using bathroom, eating at home or in a nursing home);
 - (e) Hearing aids or hearing exams;
 - (f) Expenses for eyeglasses or eye examinations for the purpose of prescribing, fitting or changing eyeglasses, hearing aids or examinations (except as covered under the Laborers' Building & Construction Vision Plan);
 - (g) Expenses and services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth except for hospitalization connected with a dental procedure when the patient has medical impairments requiring hospitalization;
 - (h) Orthopedic shoes;
 - (i) Routine foot care (except for diabetics);
 - (j) Prescription and nonprescription drugs or medicines (except as covered under the Laborers Building & Construction Prescription Plan).

HOW TO FILE A CLAIM FOR BENEFITS UNDER THE GROUP MEDICARE SUPPLEMENTAL PROGRAM

Hospital Benefits

When you receive any hospital services for which benefits are payable under Medicare, be sure to present your Medicare Card and your Laborers Building and Construction Medicare Supplement Card to the hospital. Payment of benefits for covered services, inpatient or outpatient, under the Program will be made by the Fund following payment by Medicare. Claim for services should be submitted to Medicare. Medicare will send to you and the provider an Explanation of Benefits. Your provider should then bill the Fund for additional Medicare approved amounts or amounts not paid by Medicare. The Fund will reimburse your provider or you for the benefits payable under the Program.

Benefits for Post-Hospital Skilled Nursing Care

If you are confined to a skilled nursing facility and you qualify for post-hospital skilled nursing care benefits under the Program, the skilled nursing facility or you will be reimbursed for the benefits payable under the Program. The skilled nursing facility should bill Medicare and they should also bill the Fund for any additional Medicare approved amounts not paid by Medicare.

Benefits for Physicians' Services and Medical Services

Your doctor or provider should submit your bills to Medicare. After Medicare makes the payment, your provider should then bill the Fund for the additional Medicare approved amounts not paid by Medicare. If your provider does not bill the Fund for the additional payments, you should send the Fund a copy of the Explanation of Benefits you receive from Medicare along with a copy of the bill you received from the provider.

Any questions that you may have concerning claim submission under the Group Medicare Supplemental Program should be directed to the Fund Office.

**LABORERS' DISTRICT COUNCIL
BUILDING AND CONSTRUCTION
HEALTH AND WELFARE FUND**

PENSIONERS' GROUP MEDICARE SUPPLEMENTAL PROGRAM

MEDICARE (PART A) — HOSPITAL SERVICES — MEDICARE DEDUCTIBLES AND COINSURANCE PER BENEFIT PERIOD			
<p>*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.</p> <p>Note: The Medicare payment amounts reflected below will likely change annually.</p>			
SERVICES	MEDICARE PAYS	BUILDING & CONSTRUCTION PLAN PAYS	YOU PAY
(PART A) HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$812	\$812 (Part A deductible)	\$0
61st through 90th day	All but \$203 a day	\$203 a day	\$0
91st day and after:	All but \$406	\$406 a day	\$0
<ul style="list-style-type: none"> • While using 60 lifetime reserve days 			
<ul style="list-style-type: none"> • Once lifetime reserve days are used: <ul style="list-style-type: none"> — Additional 365 days 	\$0	100% of Medicare Eligible Expenses (lifetime maximum applies)	\$0

PENSIONERS' GROUP MEDICARE SUPPLEMENTAL PROGRAM (continued)

MEDICARE (PART A) — HOSPITAL SERVICES — MEDICARE DEDUCTIBLES AND COINSURANCE PER BENEFIT PERIOD			
<p>*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.</p> <p>Note: The Medicare payment amounts reflected below will likely change annually.</p>			
SERVICES	MEDICARE PAYS	BUILDING & CONSTRUCTION PLAN PAYS	YOU PAY
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.</p>			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$101.50 a day	Up to \$101.50 a day	\$0
101st day and after	\$0	\$0	All costs
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services.</p>	All but very limited coinsurance for outpatient drugs and inpatient respite care.	\$0	\$0

PENSIONERS' GROUP MEDICARE SUPPLEMENTAL PROGRAM *(continued)*

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
*Once you have been billed \$100 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	MEDICARE PAYS	BUILDING & CONSTRUCTION PLAN PAYS	YOU PAY
(PART B)			
MEDICAL EXPENSES			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 per calendar year
Remainder of Medicare Approved Amounts	80% (50% of outpatient psychiatric services)	20% (50% of outpatient psychiatric services)	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (PA prohibits excess charges to Medicare beneficiary.)

PENSIONERS' GROUP MEDICARE SUPPLEMENTAL PROGRAM (continued)

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	BUILDING & CONSTRUCTION PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment — First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS (EXAMPLE) — NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	BUILDING & CONSTRUCTION PLAN PAYS	YOU PAY
FOREIGN TRAVEL — NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PENSIONERS' PRESCRIPTION DRUG PLAN

Eligible Pensioners and their Eligible Spouses, as previously defined, who are participating in the Group Medicare Supplemental Program, are insured under the Prescription Drug Plan. The benefits provided are the same as those previously described in the Prescription Plan Section of this Booklet.

PENSIONERS' VISION PLAN

Eligible Pensioners and their Eligible Spouses, as previously defined, are insured under the Vision Plan. The benefits provided are the same as those previously described in the Vision Plan Section of this Booklet.

SECTION XIII
CLAIM REVIEW PROCEDURES

CLAIM REVIEW PROCEDURES

(Effective for claims filed on or after January 1, 2002)

All claims for benefits must be filed in writing with the Administrator (or its designee). If your claim for a benefit under this Plan is denied in whole or in part, the Administrator, or its designee, will provide you with a written explanation of the denial. This written notice will be provided within the time period described below and will contain the following information:

- (1) the specific reason or reasons for the denial;
- (2) references to the specific Plan provisions upon which the denial is based;
- (3) a description of any additional information necessary for the claim to be honored, if that applies, and the reason why such material or information is needed;
- (4) if an internal rule or guideline was relied upon in making the denial, either a copy of the specific rule or guideline, or a statement that a copy of such rule or guideline will be provided free of charge upon request of the Plan;
- (5) if the denial is based on medical necessity or experimental treatment, either an explanation or clinical judgment of the determination applying the terms to your situation, or a statement that such explanation will be provided free of charge upon request;
- (6) a description of the Plan's review procedures and the time limits applicable to such procedures;
- (7) for an urgent care claim (defined below), a description of the expedited review process; and
- (8) a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

In the case of an adverse determination involving an urgent care claim, the information described above may be provided to you orally within the time period described below, provided that a written notice is furnished to you no later than three (3) days after the oral notification.

If your claim is not acted on within the applicable time period, you may proceed to the review procedure stage as if your claim had been denied.

Revised November 1, 2002

Here is the procedure for having your claim reviewed:

- (1) Within one hundred eighty (180) days after you receive written notice that your claim has been denied, or partly denied, you or your authorized representative may make a written request for review to the Board of Trustees. Your request should contain the following:
 - (i) Your name, address and social security number.
 - (ii) The claim number, if one appears on the notice of rejection.
 - (iii) The name of the patient, and the relationship to the member.
 - (iv) The date of service for which the claim was made.
 - (v) A statement of the reason(s) you believe your claim rejection is in error.

The Board of Trustees, or its designee, shall afford you or your authorized representative an opportunity to present written comments, documents, records, and other information relating to your claim for benefits. You or your representative shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

- (2) If your claim is wholly or partially denied on review, the Trustees, or their designee, will provide you with a written explanation of the denial. This written notice will be provided within the time period described below and will contain the following information:
 - (i) the specific reason or reasons for the denial;
 - (ii) references to the specific Plan provisions upon which the denial is based;
 - (iii) if an internal rule or guideline was relied upon in making the denial, either a copy of the specific rule or guideline, or a statement that a copy of such rule or guideline will be provided free of charge upon request of the Plan;
 - (iv) if the denial is based on medical necessity or experimental treatment, either an explanation or clinical judgment of the determination applying the terms to your situation, or a statement that such explanation will be provided free of charge upon request;
 - (v) a statement that you are entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefit; and

- (vi) a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

In exercising their duties, the Trustees, Administrator, or any person properly exercising authority delegated by the Trustees or Administrator, shall have the fullest degree of discretion allowed by law in determining eligibility for benefits, construing the terms of this Plan and related documents, and making findings of fact.

The procedures specified in this section shall be the sole and exclusive internal procedure available to the individual who is dissatisfied with a determination, or benefit award, or who is otherwise adversely affected by any action of the Trustees.

DEFINITIONS

Applicable regulations distinguish claims involving urgent care from all other categories of claims. An “urgent care claim” is defined by the regulations as:

Any claim for medical care with respect to which the application of the time periods for making non-urgent care determinations could:

- (a) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- (b) in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The applicable regulations also distinguish between pre-service and post-service claims, which are defined as follows:

- (a) A “pre-service claim” is a claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.
- (b) A “post-service claim” is any claim for a benefit that is not an urgent care claim or pre-service claim.

TIME TABLE FOR REVIEWING CLAIMS

URGENT CARE CLAIMS

To process a complete claim	72 hours
To extend previously authorized concurrent care	24 hours
(If request is made at least 24 hours before expiration of authorized period of time or number of treatments.)	
To request additional information for an incomplete claim	24 hours
Claimant's response time (at least)	48 hours
To process completed claim after receiving additional information	48 hours
Deadline for claimant to appeal after receiving Notice of Denial	180 days
Plan's notification regarding appeal	72 hours

PRE-SERVICE CLAIMS

To process a complete claim	15 days
Extension, if necessary, due to matters beyond Administrator's control	15 days
Claimant's response time to request for additional information (at least)	45 days
To process completed claim after receiving additional information	15 days
Deadline for claimant to appeal after receiving Notice of Denial	180 days
Plan's notification regarding appeal	30 days

POST-SERVICE CLAIMS (Most claims are in this category)

To process a complete claim or request additional information	30 days
Extension, if necessary, due to matters beyond Administrator's control	15 days
Claimant's response time to request for additional information (at least)	45 days
To process completed claim after receiving additional information	15 days
Deadline for claimant to appeal after receiving Notice of Denial	180 days
Plan's notification regarding appeal	*

DISABILITY CLAIMS

To process a complete claim or request additional information	45 days
Extension, if necessary, due to matters beyond Administrator's control	30 days
Claimant's response time to request for additional information (at least)	45 days
To process completed claim after receiving additional information	30 days
Deadline for claimant to appeal after receiving Notice of Denial	180 days
Plan's notification regarding appeal	*

**In most cases, after the next quarterly Trustees' meeting, if the claim is made at least 30 days prior thereto.*

In the case of a failure to follow the Plan's procedures for filing an urgent care claim or pre-service claim, you or your representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided no later than 24 hours for an urgent care claim, and no later than five (5 days) for a pre-service claim, following the failure. Notification may be oral, unless you or your representative requests written notification.

Revised November 1, 2002

EXTENSIONS

If an extension is required due to circumstances beyond the Plan Administrator's control, the claimant will be notified before the initial time period allowed for processing the claim. For example, a claimant will be notified within 30 days of receipt of a post-service claim.

FULL AND FAIR REVIEW

All claims will receive a full and fair review by the Trustees, or their designee, subject to the following:

- (1) The appeal process will be conducted by an appropriately named fiduciary who is neither the individual who decided the initial claim nor the subordinate of such individual. This named fiduciary shall have full discretionary authority to make eligibility determinations, interpret the Plan and make factual findings.
- (2) If the claim denial is based in whole or in part on a medical judgment (for example, denials based on medical necessity, medical appropriateness, experimental/investigational exclusions), the fiduciary involved will consult with a health care professional who has appropriate training and experience in the field of medicine involved in a medical judgment. The health care professional involved will not be an individual who was consulted in connection with the original denial, nor the subordinate of any such individual.
- (3) The medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial will be identified, without regard to whether the advice provided to the Fund was relied upon in making the determination.
- (4) With respect to an urgent claim, the Plan has an expedited review process pursuant to which:
 - (a) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
 - (b) All necessary information, including the Plan's determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Such review shall take into account all comments, documents, records, and other information submitted by you, or your representative, without regard to whether such information was submitted or considered in the initial benefit determination.

Revised November 1, 2002

SECTION XIV
GENERAL PROVISIONS

GENERAL PROVISIONS

PLAN NAME

The name of the Plan is the Laborers' District Council Building and Construction Health and Welfare Fund which is affiliated with Laborers' District Council of the Metropolitan Area of Philadelphia and Vicinity. The Plan is a Welfare Plan which provides hospital, medical, accident, death, weekly disability, prescription, dental, vision care and related benefits to eligible persons who participate in one or more of the provisions.

PLAN ADMINISTRATION

Overall administration of the Plan is the responsibility of the Board of Trustees whose members are appointed in equal numbers by the Laborers' District Council of the Metropolitan Area of Philadelphia and Vicinity, and The General Building Contractors Association, Inc.

In the discharge of its duties, the Board of Trustees is aided and advised by Legal Counsel, Actuarial and Accounting services as well as Administrative personnel who are responsible for all Plan and Fund records, communications and the processing of claims.

Under the Trust Agreement creating the Laborers' District Council Building and Construction Health and Welfare Fund, the Trustees have the sole and exclusive discretion and authority to make final decisions about any application or eligibility for benefits, interpretation of the Plan, findings of fact, and Administrative rules adopted by the Trustees. In these situations, the Trustees' decisions are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. A decision is to be upheld unless an arbitrator or a court of competent authority decides that the Trustees' decision is arbitrary or capricious.

AMENDMENT AND TERMINATION

The Trustees have the sole and exclusive discretion and authority to increase, decrease, change, or terminate benefits, eligibility rules or other provisions of the Plan at any time as they deem necessary for efficient administration of the Fund. These changes must be consistent with the provisions of the Trust Agreement.

The Trustees may amend or terminate this Plan of Benefits by a majority vote of the Trustees present at a duly constituted Board of Trustees meeting with a quorum present. Benefits may be adjusted upward or downward in the future reflecting the claims experience of the Plan and changing levels of income available. If the Plan is terminated, benefits for covered expenses incurred before the termination date will be paid as long as the Plan's assets are more than the Plan's liabilities.

If any provision or amendment of the Trust Agreement or the Plan is determined to be unlawful or illegal, this illegality will apply only to the provision in question, not to any other provisions of the Trust Agreement or the Plan.

PERSON DESIGNATED FOR SERVICE OF LEGAL PROCESS

The person designated by the Board of Trustees as agent for service of legal process and the address to which process may be served is:

Alan Parham
Laborers' District Council
Building and Construction Health and Welfare Fund
665 North Broad Street, 2nd Floor
Philadelphia, PA 19123

(Legal Service may also be brought upon any of the Trustees.)

PLAN RECORDS

All Plan records are maintained at the Fund Office at 665 North Broad Street, 2nd Floor, Philadelphia, PA 19123 and are available to you for inspection upon request. Any information regarding your benefits, and/or your rights under the Plan can be obtained by contacting the Plan Administrator, in writing.

TRUST QUALIFICATIONS

The Laborers' District Council Building and Construction Health and Welfare Plan has been qualified and determined exempt for tax purposes by the U.S. Internal Revenue Service. The Health and Welfare Fund Identification Number is 23-1575634, (Internal Revenue Service).

The Plan number assigned by the Trustees is 501.

The Plan's fiscal year for record keeping purposes is May 1 through April 30.

FUND ASSETS

Assets of the Fund are held in a Trust Fund and invested by professional investment manager(s) selected by the Board of Trustees.

COLLECTIVE BARGAINING AGREEMENTS

The Plan's benefits are funded through contributions determined from time to time under Collective Bargaining Agreements between the Union and the Employers. Information as it relates to the Plan's contributions is available through the Union office or the Fund Office. A copy of the applicable collective bargaining agreements may be obtained by Participants and Beneficiaries upon written request to the Plan Administrator and are available for examination in the Fund Office.

CONTRIBUTING EMPLOYERS

Complete listings of the contributing Employers and Unions party to the collective bargaining agreements are available at the Fund Office and may be obtained by Participants and Beneficiaries upon written request to the Plan Administrator.

ASSIGNMENT OF BENEFITS

No person entitled to any benefit under this Plan shall have any right to assign, alienate, anticipate or commute any such benefits and, except as otherwise prescribed by law, no such benefits shall be subject to the debts, contracts or engagements or any person entitled to such benefits, nor to any judicial process to levy upon or attach the same for the payment of such debts. This rule does not apply if the Plan Administrator determines that a domestic relations order is a Qualified Medical Child Support Order (QMCSO). The Plan does permit an exception to the general rule against assignment of benefits in limited situations; for example, for some benefits, such as medical or dental coverage, benefit payments may be assigned by a Covered Person to the physician rendering the service.

GENERAL BENEFIT EXCLUSIONS AND LIMITATIONS

Important Notice Regarding Relationship Between the Fund and Health Care Providers:

No health care provider is an agent or representative of the Fund. The Fund does not control or direct the provision of health care services and/or supplies to Covered Persons or their eligible dependents by anyone. The Fund makes no representation or guarantee of any kind concerning the quality of health care services or supplies furnished by any provider. The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the Plan of Benefits. The statement also applies to all networks or other health-related supplies to Covered Persons and their eligible dependents. Nothing in this Plan affects the ability of a health care provider to disclose alternative treatment options to a Covered Person or dependent. Although subject to benefit allowances and limitations in the Plan with regard to payment, the choice of a provider and/or treatment remains with the patient.

In addition to the exclusions provided elsewhere in this Booklet, benefits are not payable for the following:

1. Charges arising from, or occurring in the course of, any gainful occupation or employment. This exclusion applies regardless of whether a claim is actually made or filed under any applicable workers' compensation statute or program.
2. Charges for services or supplies which are not medically necessary or medically appropriate as determined by the Fund and/or its Medical Consultant.
3. Charges for treatments or procedures that are experimental or investigative.
4. Charges for treatments which are not approved by the attending physician.
5. Charges which are not Usual, Customary and Reasonable.
6. Charges in excess of the payment the provider of service accepted as payment in full from any other source.
7. Charges for custodial care.
8. Charges for service rendered by a member for the patient's immediate family (including in-laws).
9. Charges that are made because this coverage exists, or charges that no covered individual is legally obligated to pay.
10. Charges for treatments, services and/or supplies provided by the United States government, or any other government, unless you were legally required to pay for such treatments.
11. Charges resulting from war or service connected injuries or diseases.
12. Charges associated with any treatment for weight reduction.
13. Charges for hearing aids or the examination and fitting of hearing aids.
14. Charges to the extent that they are recovered from any person or organization other than an insurer of the patient.
15. Charges for cosmetic treatment and/or surgery for purposes other than breast reconstruction following a mastectomy, correction of damages caused by accidental injury, or for correction of a birth defect, providing that the patient was covered under this Plan on the date of the accident or date of birth and is still eligible as of the date of the cosmetic treatment or surgery. NOTE: SURGERY GENERALLY CONSIDERED COSMETIC IN NATURE (EVEN THOUGH FOR MEDICAL REASONS) REQUIRES PRIOR APPROVAL FROM THE FUND.

16. Charges for immunizations and vaccines (unless specifically covered under a PPO or HMO Program in which the Fund otherwise participates).
17. Charges for eye exercises, psychological testing, and learning disabilities, school or DOT physicals.
18. Charges for Counseling (including marriage counseling) or group therapy.
19. Charges for treatment of temporomandibular joint dysfunction in excess of any coverage under the Fund's Dental Benefit Plan.
20. Charges for sex change operations.
21. Charges for penile prosthetic devices.
22. Charges for the surgical correction of myopia.
23. Charges for treatment of infertility, including but not limited to, in-vitro fertilization, artificial insemination, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) and/or reversal of a sterilization procedure.
24. Charges for any other medical, dental, vision, or pharmacy service except as provided in your appropriate Summary of Benefits Schedule.
25. Also, benefits will only be paid in accordance with provisions of the Fund's various Plans. For example, Vision Care is provided for under its Vision Care Plan and will not be provided under any other provision of the Plan unless specifically included in such other Plan provision.

SUBROGATION/REIMBURSEMENT

The purpose of this provision is to insure that the limited funds available to finance the benefits provided by the Plan are not used to provide benefits where other Available Funds may be available to pay the cost of the benefits provided by the Fund.

For the purposes of this subsection the following definitions shall apply:

- (1) The term "Participant" shall mean any employee in the Plan, together with any dependent and/or beneficiary of any employee who may be entitled to benefits under the terms of the plan of benefits of the Plan.
- (2) The term "Illness or Injury" shall mean any illness or injury of whatever kind or description, whether arising out of a work related cause or whether unrelated to the work of the Participant.
- (3) The term "Available Funds" shall mean monies and/or compensation from any source whatsoever (whether called pain and suffering, weekly indemnity, workers' compensation, damages, restitution, wage loss, medical treatment, out-of-pocket expenses, or any like or similar terms).
- (4) The terms "Claim" or "Third Party Claim" shall mean any claim for monetary or non-monetary compensation of whatever kind or description whether made by petition (e.g., workers' compensation petition), court complaint, insurance claim or written or oral demand.

As a condition to the receipt of benefits from the Plan, each Participant shall agree that in the event that the Plan has made, does make, or is obligated to make payments to the Participant arising out of any Illness or Injury, then, as a condition for receiving benefits from the Plan, the Participant shall execute an agreement providing that the Participant will:

- (1) Notify the Plan in writing that a Claim relating to such Illness or Injury has been filed by the Participant against a third party seeking Available Funds.
- (2) Notify the Plan in writing of the name and address of the Participant's attorney, provide said attorney with a copy of the agreement and require said attorney to comply with its terms. The agreement shall serve as authorization to the Participant's attorney to comply with its terms and to release all requested information about the Claims to the Plan.
- (3) Keep the Plan informed in writing of the progress and/or settlement of his/her Third Party Claim.

- (4) Include in all Claims a claim for benefits paid by the Plan to and/or claimed from the Plan by the Participant, plus interest accruing from the date of payment of such benefits.
- (5) Reimburse the Plan in full for any benefits paid by the Plan to or on behalf of the Participant, plus interest accruing from the date of payment of such benefits.
- (6) Require and authorize his/her attorney, if any, to withhold from Available Funds any monies due the Plan pursuant to the agreement and to forward them to the Plan as required by the agreement. In case of any dispute over what monies are due the Plan, Available Funds are to be escrowed pending resolution of such dispute.

In the event that the Participant fails or refuses to comply with the provisions of the Plan and the agreement, then the Plan, in addition to any other rights to which the Plan or the Trustees thereof might have, shall have the right to withhold from any payments due or which become due to the Participant or to third parties on behalf of the Participant from the Plan any amount necessary until the Plan is fully reimbursed.

The Participant shall authorize the Plan to record and/or use the agreement in any proceedings involving the Participant, including using the agreement in any Third Party Claims that the Participant may have.

The Participant shall authorize any person or entity paying Available Funds to or on behalf of the Participant to pay over to the Plan such monies as the Plan is entitled to receive under the terms of the Plan and the agreement, and the agreement shall constitute their warrant to do so. In case of any dispute over what monies are due the Plan, Available Funds shall be escrowed pending resolution of such dispute.

Any Participant making a Claim on behalf of any minor child under the plan of benefits and who shall make the agreement on behalf of said minor child shall warrant that he/she is authorized to make the agreement on behalf of said minor child.

It is agreed that any payment received by the Participant from any health insurance carrier, from Blue Cross, from Blue Shield or from any like or similar plan (and excluding motor vehicle insurance), for which the Participant has paid in the full premium in order to secure individual, as distinguished from group coverage, shall be excluded from requirements of this provision.

RIGHTS AND PROTECTION UNDER ERISA

Important information required by the Employee Retirement Income Security Act (“ERISA”).

As a participant in the Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended. ERISA provides that all plan participants shall be entitled to:

- (1) Examine, without charge, at the Fund Administrator’s office and at other specified locations, such as work sites and Union halls, all plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the United States Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- (2) Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- (3) Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- (4) Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- (5) Be provided with a certificate of creditable coverage for pre-existing conditions, free of charge, when you lose coverage under the Plan, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file a suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay costs and legal fees. If it should happen that Plan Fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the 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 publication hotline of the Pension and Welfare Benefits Administration.

SECTION XV
LIST OF PROVIDERS

LIST OF PROVIDERS

MEDICAL PLAN [Self Insured]

Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103
215-557-7577
800-626-8144

PRESCRIPTION PLAN

National Prescription Administrators, Inc.
(NPA)
P.O. Box 1981
East Hanover, NJ 07936-1981
800-467-2006

Mail Order

CFI
4415 Lewis Road
Harrisburg, PA 17111
800-233-7139

VISION PLAN

National Vision Administrators (NVA)
P.O. Box 1981
East Hanover, NJ 07936-1981
800-672-7723

DENTAL PLAN

Fidelio Insurance Company
2826 Mount Carmel Avenue
Glenside, PA 19038
215-885-2443
800-262-4949

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

ReliaStar Life Insurance Co.
Minneapolis, Minnesota 55440
Claims must be submitted through
fund office at 215-236-6700

WEEKLY DISABILITY INCOME

Laborers' District Council Building and
Construction Health and Welfare Fund
665 North Broad Street, 2nd Floor
Philadelphia, PA 19123
215-236-6700

EMPLOYEE ASSISTANCE PROGRAM

Allied Trades Assistance Program
2791 Southampton Road
Philadelphia, PA 19154
800-258-6376



**LABORERS' DISTRICT COUNCIL
BUILDING & CONSTRUCTION
HEALTH & WELFARE FUND**



**Benefits underwritten or administered by QCC Ins. Co., a subsidiary of Independence Blue Cross -
Independent Licensees of the Blue Cross and Blue Shield Association.**

THE PERSONAL CHOICE
HEALTH BENEFITS PROGRAM

QCC Insurance Company
(Hereafter called "the Carrier")

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QCC Insurance Company
(Hereafter called "the Carrier")

FUND HEALTH BENEFITS BOOKLET/CERTIFICATE

The Carrier certifies that you are entitled to the benefits described in this Booklet/Certificate as subject to the eligibility and effective date requirements of the Fund Contract.

This Booklet/Certificate replaces any and all Booklet/Certificates previously issued to You under any fund contracts issued by the Carrier providing the types of benefits described in this Booklet/Certificate.

The Contract is between the Carrier and the Contractholder. This Booklet/Certificate is a summary of the Contract provisions that affect your insurance. All benefits and exclusions are subject to the terms of the Fund Contract.

ATTEST:

BY

A handwritten signature in black ink, appearing to read "G. Fred DiBona, Jr.", written in a cursive style.

G. Fred DiBona, Jr., Esq.
Chairman, President and
Chief Executive Officer

INTRODUCTION

This booklet has been prepared so that you may become acquainted with the Personal Choice health care plan offered by your employer. Coverage under your employer's plan is available to active members who are eligible for the Coverage and enrolled in it. The Personal Choice health care Coverage described in this booklet is subject to the terms and conditions of the fund contract issued by QCC Insurance Company.

Benefits will not be available for services to a greater extent or for a longer period than is Medically Necessary/Medically Appropriate, as determined by the Carrier. The amount of benefits for any Covered Service will not exceed the amount charged by the health care provider, and will not be greater than any maximum amount or limit described or referred to in this booklet.

See "Important Notice" below:

IMPORTANT NOTICE:

REGARDING EXPERIMENTAL OR INVESTIGATIVE TREATMENT:

QCC (the Carrier) does not cover treatment it determines to be Experimental or Investigative in nature because that treatment is not accepted by the general medical community for the condition being treated or not approved as required by federal or governmental agencies. However, the Carrier acknowledges that situations exist when a Covered Person and his or her physician agree to utilize Experimental or Investigative treatment. If a Covered Person receives Experimental or Investigative treatment, the Covered Person shall be responsible for the cost of the treatment. A Covered Person or his or her physician may contact the Carrier to determine whether a treatment is considered Experimental or Investigative. The term "Experimental or Investigative" is defined in the Definitions section of this booklet.

REGARDING TREATMENT WHICH IS NOT MEDICALLY APPROPRIATE/MEDICALLY NECESSARY:

The Carrier only covers treatment which it determines Medically Appropriate/Medically Necessary. A Member/Contracting Provider accepts our decision and will not bill the Covered Person for treatment which the Carrier determines is not Medically Appropriate/Medically Necessary without that person's consent. A Non-Member/ Non-Contracting Provider, however, is not obligated to accept the Carrier's determination and the Covered Person may not be reimbursed for treatment which the Carrier determines is not Medically Appropriate/Medically Necessary. The Covered Person is responsible for these charges when treatment is received by a Non-Member/Non-Contracting Provider. You can avoid these charges simply by choosing a Member/Contracting Provider for your care.

The terms "Medically Appropriate" and "Medically Necessary" are defined in the Definitions section of this booklet.

REGARDING TREATMENT FOR COSMETIC PURPOSES:

The Carrier does not cover treatment which it determines is for Cosmetic purposes because it is not necessitated as part of the Medically Appropriate/Medically Necessary treatment of an illness, injury or congenital birth defect. However, the Carrier acknowledges that situations exist when a Covered Person and his or her physician decide to pursue a course of treatment for Cosmetic purposes. In such cases, the Covered Person is responsible for the cost of the treatment. A Covered Person or his or her physician may contact the Carrier to determine whether treatment is for Cosmetic purposes.

The exclusion for services and operations for cosmetic purposes is detailed in the Exclusions section of this booklet.

DEFINED TERMS

The terms below have the following meaning when describing the benefits within this Booklet/Certificate. They will be helpful to you in fully understanding your benefits.

ACCESSIBILITY - the extent to which a member of a Managed Care Organization can obtain from a Preferred Provider available Covered Services at the time they are needed. Accessibility to a Preferred Provider refers to both telephone access and ease of scheduling an appointment.

ACCIDENTAL INJURY - bodily injury which results from an accident directly and independently of all other causes and which occurs after the Effective Date of coverage.

ACCREDITED EDUCATIONAL INSTITUTION - a publicly or privately operated academic institution of higher learning which: (a) provides recognized course or courses of instruction and leads to the conferment of a diploma, degree, or other recognized certification of completion at the conclusion of the course of study; and (b) is duly recognized and declared as such by the appropriate authority of the state in which such institution is located; provided, however, that in addition to any state recognition, the institution must also be accredited by a nationally recognized accrediting association as recognized by the United States Secretary of Education. The definition may include, but is not limited to, colleges and universities, and technical or specialized schools.

ALCOHOL OR DRUG ABUSE- any use of alcohol or other drugs which produce a pattern of pathological use causing impairment in social or occupational functions or which produces physiological dependency evidenced by physical tolerance or withdrawal.

AMBULATORY SURGICAL FACILITY - a Facility Provider, with an organized staff of Physicians, which is licensed as required and which has been approved by the Joint Commission on Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health care, Inc., or by the Carrier and which:

- A. has permanent facilities and equipment for the primary purposes of performing surgical procedures on an Outpatient basis;
- B. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- C. does not provide Inpatient accommodations; and
- D. is not, other than incidentally, a facility used as an office or clinic for the private practice of a Professional Provider.

ANCILLARY PROVIDER - an individual or entity that provides services, supplies or equipment (such as, but not limited to, Home Infusion Therapy services, Durable Medical Equipment and ambulance services), for which benefits are provided under the coverage.

ANESTHESIA - consists of the administration of regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

APPEAL - A request by a Covered Person, or the Covered Person's representative or Provider, acting on the Covered Person's behalf upon written consent, to change a previous decision made by the Carrier.

- 1. **PPO ADMINISTRATIVE APPEAL** - an appeal by or on behalf of a Covered Person that focuses on unresolved disputes or objections regarding coverage terms such as contract exclusions and non-covered benefits. Administrative appeal may present issues related to Medical Necessity or Medical Appropriateness, but these are not the primary issues that affect the outcome of the appeal.

2. **MEDICAL NECESSITY APPEAL** - request for the Carrier to change its decision, based primarily on Medical Necessity and Appropriateness, to deny or limit the provision of a Covered Service.
3. **EXPEDITED APPEAL** - a faster review of a Medical Necessity Appeal, conducted when the Carrier determines that a delay in decision making would seriously jeopardize the Covered Person's life, health, or ability to regain maximum function.

APPLICANT AGENT - any individual, association, corporation or other entity which, as representative of an Enrolled Group of Applicants and as Agent for the Applicants is acceptable to the Carrier and has agreed to pay the charges payable under this coverage to the Carrier and to receive any information from the Carrier on behalf of the Applicants.

APPLICANT AND MEMBER - you, the Member who applies for coverage under the Plan.

APPLICATION AND APPLICATION CARD - the request, either written or via electronic transfer, of the Applicant for coverage, set forth in a format approved by the Carrier.

ATTENTION DEFICIT DISORDER - a disease characterized by developmentally inappropriate inattention, impulsiveness and hyperactivity.

BENEFIT PERIOD - the specified period of time as shown in the Schedule of Benefits during which charges for Covered Services must be Incurred in order to be eligible for payment by the Carrier. A charge shall be considered Incurred on the date the service or supply was provided to a Covered Person.

BIRTH CENTER - a Facility Provider approved by the Carrier which (1) is licensed as required in the state where it is situated, (2) is primarily organized and staffed to provide maternity care, and (3) is under the supervision of a Physician or a licensed certified nurse midwife.

CASE MANAGEMENT - Comprehensive Case Management programs serve individuals who have been diagnosed with a complex, catastrophic, or chronic illness or injury. The objectives of Case Management are to facilitate access by the patient to ensure the efficient use of appropriate health care resources, link patients with preventive health care services, assist providers in coordinating prescribed services, monitor the quality of services delivered, and improve patient outcomes. Case Management supports patients and providers by locating, coordinating, and/or evaluating services for a Covered Person who has been diagnosed with a complex, catastrophic or chronic illness and/or injury across various levels and sites of care.

CERTIFIED REGISTERED NURSE- a certified registered nurse anesthetist, certified registered nurse practitioner, certified entrostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the state Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any registered professional nurses employed by a health care facility or by an anesthesiology group.

COINSURANCE - a type of cost-sharing in which the Covered Person assumes a percentage of the Covered Expense for Covered Services (such as 20 percent).

COMPLAINT - any expression of dissatisfaction, verbal or written, by a Covered Person.

COMPLICATIONS OF PREGNANCY -

- (a) conditions requiring medical treatment prior or subsequent to the termination of pregnancy whose diagnoses are distinct from pregnancy but which are adversely affected by pregnancy or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, disease of the vascular, hemopoietic, nervous, or endocrine systems, and similar medical and surgical conditions of comparable severity; but will not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy, not constituting a classifiable distinct complication of pregnancy; and
- (b) hyperemesis gravidarum and pre-eclampsia requiring hospital confinement, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

- (c) conditions requiring medical treatment after the termination of pregnancy whose diagnoses are distinct from pregnancy but which are adversely affected by pregnancy or caused by pregnancy.]

CO-PAYMENT - a type of cost-sharing in which the Covered Person pays a flat dollar amount each time a Covered Service is provided (such as a \$10 or \$15 co-payment per office visit).

COVERED EXPENSE- refers to the basis on which a Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits are calculated.

- (a) For services rendered by a Facility Provider, the term "Covered Expense" may not refer to the actual amount(s) paid by the Carrier to the Provider(s). Under the Carrier's contracts, the Carrier pays Facility Providers using bulk purchasing arrangements that permit it to pay less for services and enable it to offer the

Personal Choice Discount to its Personal Choice customers. The amount the Carrier pays at the time of any given claim may be more and it may be less than the amount used to calculate the Covered Person's liability. Rather, "Covered Expense" means the following:

- i. For services rendered by a Preferred Facility Provider, "Covered Expense" means the Facility Provider's charges for the Covered Services reduced by the Personal Choice discount in effect at the time that the services are rendered.
 - ii. For services rendered by a Non-Preferred Member Facility Provider that has a direct contractual arrangement with the Carrier, "Covered Expense" means the Facility Provider's charges for the Covered Services reduced by the Plan-wide discount in effect at the time that the services are rendered.
 - iii. For services rendered by Non-Preferred Facility Providers that have no contractual arrangement with the Carrier, "Covered Expense" means the lesser of the: (1) Facility Provider's charges, (2) Medicare Allowable Payment, or (3) Reasonable and Customary Charge for the Covered Services.
- (b) For services rendered by a Professional Provider, "Covered Expense" means the following:
 - (i) For a Preferred Professional Provider - the rate of reimbursement for Covered services the Professional Provider has agreed to accept as set forth by contract with the Personal Choice Network, or the charge, whichever is less;
 - (ii) For a Participating Professional Provider - the rate of reimbursement for Covered Services will be made in accordance with the Supplemental Medical-Surgical Health Care Contract for Out-of-Network Services;
 - (iii) For a Non-Preferred, Non-Participating Professional Provider - the amount the Carrier would have paid to a Preferred Professional Provider for the same service, or the charge, whichever is less.
 - (c) For services rendered by Ancillary Providers, "Covered Expense" means the following:
 - i. For services rendered by a Preferred Provider, "Covered Expense" means the amount that the Carrier has negotiated with the Preferred Provider as total reimbursement for the Covered Services.
 - ii. For services rendered by a Non-Preferred Provider, "Covered Expense" means the lesser of the: (1) Provider's charges, (2) Medicare Allowable Payment, or (3) Reasonable and Customary charge for the Covered Services.

COVERED PERSON - an enrolled Member or his Eligible Dependents who have satisfied the specifications of the Schedule of Eligibility. A Covered Person does not mean any person who is eligible for Medicare except as specifically stated in this booklet/certificate.

COVERED SERVICE - a service or supply specified in this booklet/certificate for which benefits will be provided by the Carrier.

CUSTODIAL CARE - provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications, which do not require the technical skills or professional training of medical or nursing personnel in order to be performed safely and effectively.

DEDUCTIBLE - a specified amount of Covered Expenses for the Covered Services that is Incurred by the Covered Person before the Carrier will assume any liability.

DETOXIFICATION - the process by which an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a licensed Facility Provider, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or other drug, or alcohol and other drug dependency factors, or alcohol in combination with drugs, as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

DISEASE MANAGEMENT - a population-based approach to identify persons who have or are at risk for a particular chronic medical condition, intervene with specific programs of care, and measure and improve outcomes. Disease Management programs use evidenced-based guidelines to educate and support patients and providers, matching interventions to patients with greatest opportunity for improved clinical or functional outcomes. Disease Management programs may employ patient education, Case Management for individual patients with disease (see definition of Case Management), provider profiling and feedback, compliance monitoring and reporting, and/or preventive medicine approaches to assist patients with chronic disease(s). Disease Management interventions are intended to both improve delivery of services in various active stages of the disease process as well as to reduce/prevent relapse or acute exacerbation of the condition.

DURABLE MEDICAL EQUIPMENT - is equipment which:

- A. can withstand repeated use;
- B. is primarily and customarily used to serve a medical purpose;
- C. generally is not useful to a person in the absence of an illness or injury; and
- D. is appropriate for use in the home.

EFFECTIVE DATE - according to the Eligibility Section, the date on which coverage for a Covered Person begins under your Personal Choice Plan.

EMERGENCY - The sudden and unexpected onset of a medical or psychiatric condition manifesting itself in acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- a. placing the Covered Person's health, or in the case of a pregnant Covered Person, the health of the unborn child, in jeopardy;
- b. serious impairment to bodily functions; or
- c. serious dysfunction of any bodily organ or part.

EMERGENCY CARE - Covered Services provided to a Covered Person in an Emergency, including Emergency Accident and Emergency Medical Services.

ENTERAL NUTRITION - the provision of nutritional requirements through a tube into the stomach or small intestine.

EXPERIMENTAL OR INVESTIGATIVE - a drug, device, medical treatment or procedure:

- A. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished; or
- B. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treatment facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
- C. if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- D. if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- E. Any drug which the FDA has determined to be contraindicated for the specific treatment for which such drug is prescribed.

FACILITY PROVIDER - an institution or entity licensed, where required, to provide care. Such facilities include:

- Ambulatory Surgical Facility
- Birth Center
- Free Standing Dialysis Facility
- Free Standing Ambulatory Care Facility
- Home Health Care Agency
- Hospice
- Hospital
- Non-Hospital Facility
- Psychiatric Hospital
- Rehabilitation Hospital
- Residential Treatment Facility
- Short Procedure Unit
- Skilled Nursing Facility

FAMILY COVERAGE - for you and one or more of your Dependents.

FREE STANDING AMBULATORY CARE FACILITY - a Facility Provider, other than a Hospital, which provides treatment or services on an Outpatient or partial basis and is not, other than incidentally, used as an office or clinic for the private practice of a Physician. This facility shall be licensed by the state in which it is located and be accredited by the appropriate regulatory body.

FREE STANDING DIALYSIS FACILITY - a Facility Provider, licensed or approved by the appropriate governmental agency and approved by the Carrier, which is primarily engaged in providing dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.

FUND or (ENROLLED FUND) - a group of Members which has been accepted by the Carrier, consisting of all those active Applicants whose charges are remitted by the Applicant's Agent together with all the Members, listed on the Application Cards or amendments thereof, who have been accepted by the Carrier.

GRIEVANCE - a request by an enrollee, or a Provider with the written consent of the enrollee, to have a Managed Care Organization review the denial of a healthcare service based on Medical Necessity and Appropriateness.

HOME HEALTH CARE AGENCY - a Facility Provider, approved by the Carrier, that is engaged in providing, either directly or through an arrangement, health care services on an intermittent basis in the patient's home in accordance with an approved home health care Plan of Treatment.

HOSPICE - a Facility Provider that is engaged in providing palliative care rather than curative care to terminally ill individuals. The Hospice must be (1) certified by Medicare to provide Hospice services, or accredited as a Hospice by the appropriate regulatory agency; and (2) appropriately licensed in the state where it is located.

HOSPITAL - a short-term, acute care, general Hospital which has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by the Carrier and which:

- (a) is a duly licensed institution;
- (b) is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians;
- (c) has organized departments of medicine;
- (d) provides 24-hour nursing service by or under the supervision of Registered Nurses;
- (e) is not, other than incidentally, a:
 - Skilled Nursing Facility;
 - nursing home;
 - Custodial Care home;
 - health resort, spa or sanitarium;
 - place for rest;
 - place for aged;
 - place for treatment of Mental Illness;
 - place for treatment of Alcohol or Drug Abuse;
 - place for provision of rehabilitation care;
 - place for treatment of pulmonary tuberculosis;
 - place for provision of Hospice care.

IDENTIFICATION CARD - the currently effective card issued to you by the Carrier.

IMMEDIATE FAMILY - the Member's spouse, parent, child, stepchild, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law.

INCURRED - a charge shall be considered incurred on the date you or your Covered Dependent receives the service or supply for which the charge is made.

INDEPENDENT CLINICAL LABORATORY - a laboratory that performs clinical pathology procedure and that is not affiliated or associated with a Hospital, Physician or Facility Provider.

INPATIENT ADMISSION or (INPATIENT) - your actual entry into a Hospital, extended care facility or Facility Provider to receive Inpatient services as a registered bed patient in such Hospital, extended care facility or Facility Provider and for whom a room and board charge is made; the Inpatient Admission shall continue until such time as you are actually discharged from the facility.

INPATIENT CARE FOR ALCOHOL OR DRUG ABUSE- the provision of medical, nursing, counseling or therapeutic services twenty-four hours a day in a Hospital or Non-Hospital Facility, according to individual treatment plans.

LICENSED PRACTICAL NURSE (LPN) - a nurse who has graduated from a formal practical or nursing education program and is licensed by the appropriate state authority.

MAINTENANCE - continuation of care and management of the patient when the therapeutic goals of a treatment plan have been achieved, no additional functional improvement is apparent or expected to occur, and the provision of Covered Services for a condition ceases to be of therapeutic value.

MANAGED CARE ORGANIZATION (MCO) - a generic term for any organization that manages and controls medical service. It includes HMOs, PPOs, managed indemnity insurance programs and managed BCBS programs.

MAXIMUM - a limit on the amount of Covered Services that you may receive. The Maximum may apply to all Covered Services or selected types. When the Maximum is expressed in dollars, this Maximum is measured by the Covered Expenses, less deductibles, coinsurance and co-payment amounts paid by Covered Persons for the Services to which the Maximum applies. The Maximum may not be measured by the actual amounts paid by the Carrier to the Providers. A Maximum may also be expressed in number of days or number of services for a specified period of time.

- A. Benefit Maximum - the greatest amount of a specific Covered Service that a Covered Person may receive.
- B. Lifetime Maximum - the greatest amount of Covered Services that a Covered Person may receive in his lifetime.

MEDICAL CARE - services rendered by a Professional Provider within the scope of his license for the treatment of an illness or injury.

MEDICAL FOODS - liquid nutritional products which are specifically formulated to treat one of the following genetic diseases: phenylketonuria, branched-chain ketonuria, galactosemia, homocystinuria.

MEDICALLY APPROPRIATE (or MEDICAL APPROPRIATENESS) - services or supplies provided by a Facility Provider that the Carrier determines are:

- A. ordered by a Professional Provider or other appropriately licensed health care professional; and
- B. required for the diagnosis, or the direct care and treatment of your condition, illness, disease or injury; and
- C. appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury; and
- D. in accordance with standards of good medical practice as generally recognized and accepted by the medical community; and
- E. not primarily for the convenience of your Immediate Family, or of the Facility Provider or Professional Provider; and
- F. the most efficient and economical 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 a bed patient due to the nature of the services rendered for your condition, and you cannot receive safe and adequate care in some other setting without adversely affecting your condition or quality of Medical Care.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY) - services or supplies provided by a Professional Provider that the Carrier determines are:

- A. appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury;
- B. provided for the diagnosis, or the direct care and treatment of your condition, illness, disease or injury;
- C. in accordance with current standards of good medical practice;
- D. not primarily for your convenience, or the convenience of your Professional Provider; and
- E. the most efficient and economical 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 a bed patient due to the nature of the services rendered for your condition, and you cannot receive safe and adequate care in some other setting without adversely affecting your condition or quality of Medical Care.

MEDICARE - the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

MEDICARE ALLOWABLE PAYMENT – means the payment amount, as determined by the Medicare program, for a Covered Service or supply.

MEMBER- an individual of the Fund who meets the eligibility requirements for enrollment, who is so specified for enrollment, and in whose name the Identification Card is issued.

MEMBER FACILITY PROVIDER - a Facility Provider that is not part of the Personal Choice Network but is approved by and has a contractual relationship with the Carrier for the provision of services to Covered Persons.

NON-HOSPITAL FACILITY - a Facility Provider, licensed by the Department of Health for the care or treatment of Alcohol or Drug dependent persons, except for transitional living facilities. Non-Hospital Facilities shall include, but not be limited to, Residential Treatment Facilities and Freestanding Ambulatory Care Facilities for Partial Hospitalization Programs.

NON-HOSPITAL RESIDENTIAL TREATMENT - the provision of medical, nursing, counseling, or therapeutic services to patients suffering from alcohol or drug abuse or dependency in a residential environment, according to individualized treatment plans.

NON-MEMBER FACILITY PROVIDER - a Facility Provider that does not have a contractual relationship with the Carrier for the provision of services to Covered Persons.

NON-PARTICIPATING PROFESSIONAL PROVIDER - a Professional Provider who has not agreed to accept a rate of reimbursement determined by a contract with the Carrier for the provision of Covered Services to Covered Persons.

NON-PREFERRED ANCILLARY PROVIDER - an Ancillary Provider that is not a member of the Personal Choice Network or any other Blue Cross or Blue Shield PPO network.

NON-PREFERRED FACILITY PROVIDER - a Facility Provider that is not a member of the Personal Choice Network or any other Blue Cross or Blue Shield PPO network.

NON-PREFERRED PROFESSIONAL PROVIDER - a Professional Provider who is not a member of the Personal Choice Network or any other Blue Cross or Blue Shield PPO network.

NON-PREFERRED PROVIDER - a Facility Provider, Professional Provider or Ancillary Provider that is not a member of the Personal Choice Network or any other Blue Cross or Blue Shield PPO network.

NUTRITIONAL FORMULA - liquid nutritional products which are formulated to supplement or replace normal food products.

OUT-OF-POCKET LIMIT - a specified dollar amount of Coinsurance expense Incurred by a Covered Person for Covered Services in a Benefit Period. Such expense does not include any Deductible, penalties, Inpatient or Outpatient mental health services, or Copayment amounts. When the Out-of-Pocket Limit is reached, the level of benefits is increased as specified in the Schedule of Benefits.

OUTPATIENT - a Covered Person who receives services or supplies while not an Inpatient.

OUTPATIENT DIABETIC EDUCATION PROGRAM - an outpatient diabetic education program provided by a Preferred Facility Provider which has been recognized by the Department of Health or the American Diabetes Association as meeting the national standards for Diabetes Patient Education Programs established by the National Diabetes Advisory Board.

PARTIAL HOSPITALIZATION - medical, nursing, counseling or therapeutic services provided on a planned and regularly scheduled basis in a Hospital or Facility Provider, designed for a patient who would benefit from more intensive services than are offered in Outpatient treatment but who does not require Inpatient confinement.

PARTICIPATING PROFESSIONAL PROVIDER - a Professional Provider who has agreed to a rate of reimbursement determined by contract for the provision of Covered Services to Covered Persons.

PERSONAL CHOICE DISCOUNT - the percentage reduction from hospital billed charges for Covered Services that the Carrier passes on to its Personal Choice customers as a share of the savings the Carrier is expected to realize from its negotiated hospital contracts with Preferred Facility Providers. The amount of the Personal Choice Discount may be changed prospectively from time to time. The Personal Choice Discount is on file with the Pennsylvania Insurance Department.

PERVASIVE DEVELOPMENTAL DISORDERS (PDD) - disorders characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of

stereotyped behavior, interests and activities. Examples are Asperger's syndrome and childhood disintegrative disorder.

PHYSICIAN - a person who is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), licensed, and legally entitled to practice medicine in all its branches, perform Surgery and dispense drugs.

PLAN OF TREATMENT - a plan of care which is prescribed in writing by a Professional Provider for the treatment of an injury or illness. The Plan of Treatment should be limited in scope and extent to that care which is Medically Appropriate/Medically Necessary for the Covered Person's diagnosis and condition.

PLAN-WIDE DISCOUNT - the percentage reduction from hospital charges for Covered Services that the Carrier passes on to its customers as a share of the savings the Carrier is expected to realize from its negotiated hospital contracts. The amount of the discount may be changed prospectively from time to time. The amount of the discount is on file with the Pennsylvania Insurance Department.

PRECERTIFICATION - prior assessment by the Carrier or designated agent that proposed services, such as hospitalization, are Medically Appropriate and Necessary for a particular patient and covered by the patient's Personal Choice plan. Payment for services depends on whether the patient and the category of service are covered under the individual's plan of coverage.

PREFERRED ANCILLARY PROVIDER - an Ancillary Provider that is a member of the Personal Choice Network and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services and/or supplies to Covered Persons.

PREFERRED FACILITY PROVIDER - a Facility Provider that is a member of the Personal Choice Network and has agreed to a rate of reimbursement determined by contract for the provision of "in-network" Covered Services to Covered Persons.

PREFERRED PROFESSIONAL PROVIDER - a Professional Provider who is a member of the Personal Choice Network and has agreed to a rate of reimbursement determined by contract for "in-network" Covered Services rendered to a Covered Person.

PREFERRED PROVIDER - a Facility Provider, Professional Provider or Ancillary Provider that is a member of the Personal Choice Network, authorized to perform specific “in-network” Covered Services at the Preferred level of benefits.

PREFERRED PROVIDER ORGANIZATION (PPO) - a type of managed care plan that offers the freedom to choose a physician like a traditional health care plan and provides the physician visits and preventive benefits normally associated with an HMO (Health Maintenance Organization). In a PPO, an individual is not required to select a primary care physician to coordinate care, and is not required to obtain referrals to see specialists.

PRIMARY CARE SERVICES - basic, routine medical care traditionally provided to individuals with common illnesses and injuries and chronic illnesses.

PRIVATE DUTY NURSING- Medically Necessary/Medically Appropriate Outpatient continuous skilled nursing services provided to a Covered Person by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

PROFESSIONAL PROVIDER - a person or practitioner licensed where required and performing services within the scope of such licensure. The Professional Providers are:

- | | |
|-----------------------------------|----------------------|
| - Certified Registered Nurse | - Nurse Midwife |
| - Chiropractor | - Optometrist |
| - Dentist | - Physical Therapist |
| - Independent Clinical Laboratory | - Physician |
| - Audiologist | - Podiatrist |
| - Speech-language pathologist | - Psychologist |
| - Teacher of the hearing impaired | |

PROVIDER - a Facility Provider, Professional Provider or Ancillary Provider, licensed where required.

PSYCHIATRIC HOSPITAL - a Facility Provider, approved by the Carrier, which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

PSYCHOLOGIST - a Psychologist who is licensed in the state in which he practices; or a Psychologist who is otherwise duly qualified to practice by a state in which there is no Psychologist licensure.

REASONABLE AND CUSTOMARY - means the amount that is the usual or customary charge for the service or supply as determined by the Carrier. The chosen standard is an amount which is most often charged by other providers for similar services or supplies within the same geographic area where the service or supply is provided and who have training, experience and professional standing comparable to those of the actual provider of the service or supply. If no comparison exists, the Carrier determines what is reasonable by the severity and/or complexity of the patient’s condition for which the service or supply is provided.

REGISTERED NURSE (R.N.) - a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by the appropriate state authority.

REHABILITATION HOSPITAL - a Facility Provider, approved by the Carrier, which is primarily engaged in providing rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve the highest possible level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

RESIDENTIAL TREATMENT FACILITY - a Facility Provider, licensed and approved by the appropriate government agency and approved by the Carrier, which provides treatment for Mental Illness or for substance (Alcohol and Drug) abuse to partial, outpatient or live-in patients who do not require acute Medical Care.

RESTORATIVE SERVICES - courses of treatments prescribed or provided by Professional Providers to restore loss of function of a body part. Restorative services generally involve neuromuscular training as a course of treatments over weeks or months. Examples of restorative services include, but are not limited to:

- Manipulative treatment of functional loss from back disorder
- Therapy treatment of functional loss following foot surgery
- Treatment of oculomotor dysfunction

SERIOUS MENTAL ILLNESS - means any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the diagnostic and statistic manual: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

SEVERE SYSTEMIC PROTEIN ALLERGY - means allergic symptoms to ingested proteins of sufficient magnitude to cause weight loss or failure to gain weight, skin rash, respiratory symptoms, and gastrointestinal symptoms of significant magnitude to cause gastrointestinal bleeding and vomiting.

SHORT PROCEDURE UNIT - a unit which is approved by the Carrier and which is designed to handle either lengthy diagnostic or minor surgical procedures on an Outpatient basis which would otherwise have resulted in an Inpatient stay in the absence of a Short Procedure Unit.

SKILLED NURSING FACILITY - an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of Mental Illness, tuberculosis, or Alcohol or Drug Abuse, which:

- is accredited as a Skilled Nursing Facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- is certified as a Skilled Nursing Facility or extended care facility under the Medicare Law; or
- is otherwise acceptable to the Carrier.

SURGERY - the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other invasive procedures. Payment for Surgery includes an allowance for related Inpatient preoperative and postoperative care. Treatment of burns, fractures and dislocations are also considered surgery.

THERAPY SERVICE - the following services or supplies prescribed by a Physician and used for the treatment of an illness or injury to promote the recovery of the Covered Person:

- RADIATION THERAPY**
The treatment of disease by X-Ray, gamma ray, accelerated particles, mesons, neutrons, radium, radioactive isotopes, or other radioactive substances regardless of the method of delivery.
- CHEMOTHERAPY**
The treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetics, and other related biotech products.
- DIALYSIS**
The treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body.
- CARDIAC REHABILITATION THERAPY**
Medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.

- E. **PHYSICAL THERAPY**
Medically prescribed treatment of physical disabilities or impairments resulting from disease, injury, congenital anomaly, or prior therapeutic intervention by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility and the functional activities of daily living.
- F. **RESPIRATORY THERAPY**
Medically prescribed treatment of diseases or disorders of the respiratory system with therapeutic gases and vaporized medications delivered by inhalation.
- G. **OCCUPATIONAL THERAPY**
Medically prescribed treatment concerned with improving or restoring neuromusculoskeletal functions which have been impaired by illness or injury, congenital anomaly or prior therapeutic intervention. Occupational therapy also includes medically prescribed treatment concerned with improving the Covered Person's ability to perform those tasks required for independent functioning where such function has been permanently lost or reduced by illness or injury, congenital anomaly or prior therapeutic intervention. This does not include services specifically directed towards the improvement of vocational skills and social functioning.
- H. **SPEECH THERAPY**
Medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.
- I. **INFUSION THERAPY**
Treatment including, but not limited to infusion or inhalation, parenteral and Enteral Nutrition, antibiotic therapy, pain management and hydration therapy.
- J. **PULMONARY REHABILITATION THERAPY**
Multidisciplinary treatment which combines physical therapy with an educational process directed at stabilizing pulmonary diseases and improving functional status.

TOTAL DISABILITY - means that you, due to illness or injury, cannot perform any duty of your occupation or any occupation for which you are, or may be, suited by education, training and experience, and you are not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Totally Disabled person must be under the regular care of a Physician.

SCHEDULE OF BENEFITS

Subject to the exclusions, conditions and limitations of the Carrier as set forth in the booklet/certificate, a Covered Person is entitled to benefits for the Covered Services described in this Benefits section during a Benefit Period, subject to the Deductible, if any, and in the amounts as specified in this Schedule of Benefits. The term "Preferred" means "In-Network" and the term "Non-Preferred" means "Out-of-Network".

The percentages shown for your Coinsurance and Covered Services below are not always calculated on actual charges. For an explanation on how your Coinsurance is calculated, see the "Covered Expense" definition in the DEFINED TERMS section of the booklet\certificate.

BENEFIT PERIOD	Calendar Year
PROGRAM DEDUCTIBLE (Covered Person's Liability) (Preferred Care) (Non-Preferred Care)	None \$250 per Benefit Period per Covered Person. This Deductible applies to all services, except: Emergency Care Services, Medical Foods, pediatric immunizations, routine gynecological examination, Pap smear and mammograms.
FAMILY DEDUCTIBLE (Non-Preferred Care) DEDUCTIBLE CARRYOVER	The family Deductible amount is equal to 2 times the individual Deductible. In each Benefit Period, it will be applied for all family members covered under a Family Coverage. A Deductible will not be applied to any covered individual family member once that covered individual has satisfied the individual Deductible, or the family Deductible has been satisfied for all covered family members combined. Expenses Incurred for Covered Expenses in the last three months of a Benefit Period which were applied to that Benefit Period's Deductible will be applied to the Deductible of the next Benefit Period.

<p>COINSURANCE</p> <p>(Covered Person’s Liability)</p> <p>(Preferred Care)</p> <p>(Non-Preferred Care)</p>	<p>None</p> <p>20% for Covered Services; except Coinsurance does not apply to Emergency Care Services.</p>
<p>OUT-OF-POCKET LIMIT</p> <p>(Preferred Care)</p> <p>(Non-Preferred Care)</p>	<p>None</p> <p>When a Covered Person Incurs \$1,000 of Coinsurance expense in one Benefit Period for Non-Preferred Covered Services, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. After two (2) times the individual Out-of-Pocket Limit amount has been Incurred for Covered Services by Covered Persons under the same Family Coverage in a Benefit Period, the Coinsurance percentage will be reduced to 0% for the balance of that Benefit Period. However, no family member will contribute more than the individual Out-of-Pocket Limit amount. The dollar amounts specified shall not include any expense Incurred for any Deductible, Penalty or Co-payment amount.</p>
<p>LIFETIME MAXIMUM</p> <p>(Preferred Care)</p> <p>(Non-Preferred Care)</p>	<p>Unlimited</p> <p>\$1,000,000 per lifetime per Covered Person for Non-Preferred Covered Services.</p>
<p>REINSTATEMENT</p> <p>(Preferred/Non-Preferred Care)</p>	<p>Amounts applied to a Covered Person’s Lifetime Maximum are not restorable.</p>

SERVICES	PREFERRED	NON-PREFERRED
<p>ASSISTANT SURGEON</p> <p>If more than one surgical procedure is performed by the same Professional Provider during the same operative session, the Carrier shall pay the charge for the highest paying procedure and no allowance for additional procedures except where the Carrier deems that an additional allowance is warranted.</p>	100%	80%
<p>ANESTHESIA</p> <p>Services administered by a nurse anesthetist not employed by a Professional Provider are paid at 50%.</p>	100%	80%
<p>SECOND SURGICAL OPINION Voluntary</p>	100%	80%
<p>MEDICAL CARE</p> <p>Inpatient Care Concurrent Care (Inpatient Consultations Consultations are limited to 1 consultation per consultant per confinement)</p>	100%	80%
<p>DIAGNOSTIC SERVICES - OUTPATIENT</p> <p>X-Ray: Radiology, Ultrasound and Nuclear Medicine, ECG, EEG, Other</p> <p>Laboratory, Pathology</p> <p>Allergy Testing</p> <p>Failure to obtain a preprocedure certification for certain Non-Preferred diagnostic procedures will result in a 20% reduction in the benefits payable for such services</p>	<p>100%</p> <p>100%</p> <p>100%</p>	<p>80%</p> <p>80%</p> <p>80%</p>

SERVICES	PREFERRED	NON-PREFERRED
<p>THERAPY – OUTPATIENT</p> <p>Radiation Therapy, Chemotherapy and Dialysis Therapy</p> <p>Failure to obtain pre-certification for the following Non-Preferred Therapy services will result in a 20% reduction in benefits payable.</p> <p>Infusion Therapy</p> <p>Respiratory Therapy</p> <p>Cardiac Rehabilitation Therapy 18 Preferred/Non-Preferred sessions per Benefit Period.</p> <p>Pulmonary Rehabilitation Therapy 12 Preferred/Non-Preferred sessions per Benefit Period</p> <p>Failure to obtain pre-certification for Non-Preferred services will result in a 20% reduction in benefits payable for Physical, Occupational and Speech Therapy services.</p> <p>Physical, Occupational, Speech Therapy</p>	<p>100%</p> <p>100%</p> <p>100%, less \$10 Co-payment per session</p>	<p>80%</p> <p>80%</p> <p>80%</p> <p>80%</p> <p>80%</p>
<p>RESTORATIVE SERVICES</p> <p>Failure to pre-certify Non-Preferred services will result in a 20% reduction in benefits payable for Restorative Services</p>	<p>100%, less \$10 Co-payment per session</p>	<p>80%</p>
<p>MATERNITY SERVICES (Excluded for Dependent daughters)</p> <p>Obstetrical/Maternity Care</p> <p>Elective abortions</p> <p>Newborn care</p>	<p>100%</p> <p>100%</p> <p>100%</p>	<p>80%</p> <p>80%</p> <p>80%</p>

SERVICES	PREFERRED	NON-PREFERRED
<p>SKILLED NURSING FACILITY CARE (SNF)</p> <p>Failure to pre-certify Non-Preferred services will result in a \$1,000 reduction in benefits payable for these services.</p> <p>Physician visit limits per Benefit Period: Two (2) visits during first week of confinement and one (1) visit per week for each consecutive week of confinement thereafter.</p>	100%	80%
<p>DURABLE MEDICAL/SURGICAL EQUIPMENT</p> <p>Pre-certification is required for Non-Preferred supplies including all rentals and for purchase of items with a billed amount that exceeds \$100.</p>	100%	80%
<p>PROSTHETICS</p> <p>Pre-certification of Non-Preferred supplies is required for items with a billed amount that exceeds \$100 in value.</p>	100%	80%
<p>HOME HEALTH CARE</p> <p>Failure to pre-certify Non-Preferred services will result in a 20% reduction in benefits payable for Home Health Care services</p>	100%	80%
<p>HOSPICE CARE</p> <p>Respite Care - Maximum of seven (7) days every six (6) months.</p> <p>Failure to pre-certify Non-Preferred services will result in a 20% reduction in benefits payable for Hospice Care services.</p>	100%	80%

SERVICES	PREFERRED	NON-PREFERRED
<p>AMBULANCE</p> <p>Failure to pre-certify Non-Preferred, Non-emergency services will result in a 20% reduction in benefits payable for non-emergency ambulance services.</p>	100%	80%
<p>MEDICAL FOODS AND NUTRITIONAL FORMULAS</p> <p>(Deductibles do not apply to Medical Foods benefits.)</p>	100%	80%
<p>TRANSPLANT SERVICES</p> <p>Failure to pre-certify Non-Preferred, Inpatient transplants will result in a \$1,000 reduction in benefits payable for these services.</p> <p>Failure to pre-certify Non-Preferred, Outpatient transplants will result in a 20% reduction in benefits payable for these services</p>	100%	80%
<p>OUTPATIENT PRIVATE DUTY NURSING</p> <p>Failure to pre-certify Non-Preferred services will result in a 20% reduction in benefits payable.</p>	100%	80%
<p>OUTPATIENT DIABETIC EDUCATION PROGRAM</p> <p>Co-payments, Deductibles and Coinsurance do not apply to this benefit. Non-Preferred services are not available for this benefit.</p>	100%	0%
<p>BLOOD</p>	100%	80%

SERVICES	PREFERRED	NON-PREFERRED
<p>PRIMARY CARE</p> <p>Home, office, Outpatient visits and Outpatient Consultations</p> <p>Pediatric Preventive Care</p> <p>Pediatric immunizations (Co-payments, Deductibles and Maximum amounts do not apply to this benefit)</p> <p>Adult Preventive Care</p>	<p>100%, less \$5 Co-payment per visit</p> <p>100%, less \$5 Co-payment per visit</p> <p>100%</p> <p>100%, less \$5 Co-payment per visit</p>	<p>80%</p> <p>80%</p> <p>80%</p> <p>80%</p>
<p>Routine Gynecological Exam and Pap Smears (Co-payments, Deductibles and Maximum amounts do not apply to this benefit)</p> <p>Mammograms (Deductibles do not apply)</p> <p>Therapeutic injections</p> <p>Allergy Extract/Injections</p>	<p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>80%</p> <p>80%</p> <p>80%</p> <p>80%</p>
<p>DIABETIC EQUIPMENT AND SUPPLIES (Subject to Copayment, Deductible and precertification requirements applicable to Durable Medical Equipment benefits.)</p>	<p>100%</p>	<p>80%</p>

YOUR PERSONAL CHOICE NETWORK PLAN

Your Personal Choice Network Plan (the Plan) is a program, which allows you to maximize your health care benefits by utilizing the Personal Choice Preferred Provider Organization's Providers. These Providers are called "Preferred Providers" in this Booklet/Certificate. You may think of them as "In-Network Providers". Preferred Providers are doctors, hospitals and other health care professionals and institutions that are part of the Personal Choice Network. Personal Choice Preferred Provider benefits are delivered through a specially selected, highly managed network of cost-effective providers to ensure quality care. The Personal Choice Network includes hospitals, primary care physicians and specialists, and a wide range of ancillary providers, including suppliers of durable medical equipment, hospice care and home health agencies, skilled nursing facilities, free standing dialysis centers and ambulatory surgical centers.

When you receive health care through a Provider that is a member of the Personal Choice Network, you are assured of little, if any, out-of-pocket expenses, and there are no claim forms to fill out. Benefits are also provided if you choose to receive health care through a Provider that is not a Preferred Provider. However, the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses. You may have to reach a deductible before receiving benefits, and you may be required to file a claim form.

A directory of the Preferred Providers who belong to the Personal Choice Network is available to you upon request. It will identify the Professional Providers who have agreed to become Preferred Professional Providers and will also identify the Hospitals in the Network with which the Preferred Professional Providers are affiliated. Also included in the directory is a listing of the ancillary providers affiliated with the Personal Choice Network. The directory is updated periodically throughout the year, and the Carrier reserves the right to add or delete physicians and/or hospitals at any given time. It is important to know that continued participation of any one doctor, hospital or other provider cannot be guaranteed. For information regarding Providers that participate in the Personal Choice Network, call the Health Resource Center at 1-800-ASK BLUE.

The Carrier covers only care that is Medically Appropriate/Medically Necessary. Medically Appropriate care is care that is needed for your particular condition and that you receive at the most appropriate level of service. Examples of different levels of service are Hospital Inpatient care, treatment in Short Procedure Units and care in a Hospital Outpatient Department.

Some of the services you receive through this Plan must be pre-certified before you receive them, to determine whether they are Medically Appropriate. Failure to pre-certify Non-Preferred services, when required, may result in a reduction of benefits. Precertification of services is a vital program feature that reviews Medical Appropriateness of certain procedures/admissions. In certain cases, precertification helps determine whether a different treatment may be available that is equally effective yet less traumatic. Precertification also helps determine the most appropriate setting for certain services. The latest innovations in health care enable doctors to provide services, once provided exclusively in an inpatient setting, in many different settings – such as an outpatient department of a hospital or a doctor's office.

When you need seek medical treatment that requires precertification, you are not responsible for obtaining the precertification if treatment is provided by a Personal Choice Network Provider. In addition, if the Personal Choice Network Provider fails to obtain a required precertification of services, you will be held harmless from any associated financial penalties assessed by the Plan as a result. If the request for precertification is denied, you will be notified in writing that the admission/service will not be paid because it is considered to be medically inappropriate. If you decide to continue treatment or care that has not been approved, you will be asked to do the following:

1. Acknowledge this in writing.
2. Request to have services provided.
3. State your willingness to assume financial liability.

When you seek treatment from a Non-Preferred Provider or a Blue Card provider of another Blue Cross or Blue Shield plan, you are responsible for initiating the precertification process. You or your provider should call the precertification number listed on the back of your Identification Card, and give your name, facility's name, diagnosis, and procedure or reason for admission. Failure to precertify required services will result in a reduction of benefits payable to you.

PAYMENT OF PROVIDERS

I NETWORK PROVIDER REIMBURSEMENT

Personal Choice reimbursement programs for health care providers are intended to encourage the provision of quality, cost-effective care for Personal Choice members. Set forth below is a general description of Personal Choice reimbursement programs, by type of Personal Choice Network health care provider.

Please note that these programs may change from time to time, and the arrangements with particular providers may be modified as new contracts are negotiated. If you have any questions about how your health care provider is compensated, please speak with your healthcare provider directly or contact Member Services.

Physicians

Personal Choice Network physicians, including primary care physicians (PCPs) and specialists, are paid on a fee-for-service basis, meaning that payment is made according to our Personal Choice fee schedule for the specific medical services that the physician performs.

Institutional Providers

Hospitals: For most Inpatient medical and surgical services, Hospitals are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the Hospital. These rates usually vary according to the intensity of the Covered Services provided. Some Hospitals are also paid case rates, which are set dollar amounts paid for a complete Hospital stay related to a specific procedure or diagnosis, e.g., transplants. For most Outpatient and Emergency Services and procedures, most Hospitals are paid specific rates based on the type of Covered Service performed. For a few Covered Services, Hospitals are paid based on a percentage of billed charges. Most Hospitals are paid through a combination of the above payment mechanisms for various services.

Skilled Nursing Facilities, Rehabilitation Hospitals, and other care facilities: Most Skilled Nursing Facilities and other special care facilities are paid per diem rates, which are specific amounts paid for each day a Covered Person is in the facility. These amounts may vary according to the intensity of the Covered Services provided.

Ambulatory Surgical Centers (ASCs): Most ASCs are paid specific rates based on the type of Covered Service performed. For a few services, some ASCs are paid based on a percentage of billed charges.

Physician Group Practices, Physician Associations and Integrated Delivery Systems

Certain physician group practices, independent physician associations (IPAs) and integrated hospital/physician organizations called Integrated Delivery Systems (IDS) employ or contract with individual physicians to provide medical services. These groups are paid as described in the physicians reimbursement section outlined above. These groups may pay their affiliated physicians a salary and/or provide incentives based on production, quality, service, or other performance standards.

Ancillary Service Providers, certain Facility Providers and Mental Health/Substance Abuse Providers

Ancillary service providers, such as Durable Medical Equipment providers, laboratory providers, Home Health Care agencies, and Mental Health and Substance Abuse providers are paid on the basis of fee-for-service payments according to our Personal Choice fee schedule for the specific Covered Services performed.

In some cases, such as for mental health and substance abuse benefits, one vendor arranges for all such services through a contracted set of providers. We reimburse the contracted providers of these vendors on a fee-for-service basis.

Hospitalists

We have contracted with an organization that has contracted with a network of participating physicians (Hospitalists) who specialize in providing emergency room consultation and inpatient management services in certain hospitals. Some Personal Choice Network physicians have elected to have these Hospitalist physicians care for their patients when their patients are admitted to a Hospital. The hospitalist organization and its network physicians are eligible to receive a quality incentive payment based on certain quality criteria.

II. PAYMENT METHODS

Covered Person or the Provider may submit bills directly to the Carrier, and, to the extent that benefits and indemnity are payable within the terms and conditions of this coverage, reimbursement will be furnished as detailed below. The Covered Person's Deductibles, Coinsurance, benefit Maximums and benefits for Covered Services are based on the rate of reimbursement as defined under "Covered Expense" in the "DEFINED TERMS" section of this Booklet-Certificate.

Facility Providers

Preferred Facility Providers

Preferred Facility Providers are members of the Personal Choice Network and have a contractual arrangement with the Carrier for the provision of services to Covered Persons. Benefits will be provided as specified in the Schedule of Benefits for services which have been performed by a Preferred Facility Provider. The Carrier will compensate Preferred Facility Providers in accordance with the contracts entered into between such Providers and the Carrier. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Facility Provider.

Non-Preferred Facility Providers

Non-Preferred Facility Providers include facilities that are not part of the Personal Choice Network. The Carrier may have a contractual arrangement with a facility even if it is not part of the Personal Choice Network. Non-Preferred Member Facility Providers that have contracts with the Carrier will be compensated in accordance with the contracts entered into between such Providers and the Carrier.

A Non-Preferred Non-Member Facility Provider is a Facility Provider which does not belong to the Personal Choice Network, nor does it have a contract with the Carrier. The Carrier will provide benefits at a Non-Preferred Non-Member Provider at the Non-Preferred coinsurance level specified in the Schedule of Benefits.

If the Carrier determines that Covered Services were for Emergency Care as defined herein, the Covered Person will not be subject to the deductible or coinsurance penalties that would ordinarily be applicable to Non-Preferred services. Emergency admissions must be certified within two (2) business days of admission, or as soon as reasonably possible, as determined by the Carrier.

The Carrier will provide benefits for the Covered Expenses incurred for certain medical services when rendered incident to hospitalization, as described herein. If charges for such services are included in a bill from a Preferred Facility Provider or a Member Facility Provider, payment shall be made to such Facility Provider subject to any existing agreement between the Facility Provider and the Carrier.

Once Covered Services are rendered by a Facility Provider, the Plan will not honor a Covered Person's request not to pay for claims submitted by the Facility Provider. The Covered Person will have no liability to any person because of its rejection of the request.

Professional Providers

The Carrier is authorized by the Covered Person to make payment directly to the Preferred and Participating Professional Providers furnishing Covered Services for which benefits are provided under this coverage. Preferred and Participating Professional Providers have agreed to accept the rate of reimbursement determined by a contract as payment in full for Covered Services. BlueCard PPO Providers will be compensated by the Blue Cross and Blue Shield Plans with which they contract. Preferred and Participating Professional Providers will make no additional charge to Covered Persons for Covered Services except in the case of certain Co-Payments, Coinsurance or other cost

sharing features as specified under this program. The Covered Person is responsible within 60 days of the date in which the Carrier finalizes such services to pay, or make arrangements to pay, such amounts to the Preferred and Participating Professional Provider.

Benefit amounts, as specified in the Schedule of Benefits of this coverage, refer to Covered Services rendered by a Professional Provider which are regularly included in such Provider's charges and are billed by and payable to such Provider. Any dispute between the Preferred Professional Provider and a Covered Person with respect to balance billing shall be submitted to the Carrier for determination. The decision of the Carrier shall be final.

Non-Preferred Professional Provider Reimbursement

When Covered Services are performed by a Non-Preferred Professional Provider, the Carrier will make payment to the Covered Person, subject to any applicable Coinsurance or other cost sharing penalty on services by Non-Preferred Professional Providers. When a Covered Person seeks care from a Non-Preferred Participating Professional Provider, payment will be made in accordance with the rate of reimbursement determined by the contract between the Professional Provider and the Carrier. When a Covered Person seeks care from a Non-Preferred, Non-Participating Professional Provider, payment will be the amount the Carrier would have paid to a Preferred Professional Provider for the same service or the charge, whichever is less. Accordingly, when a Covered Person seeks care from Non-Preferred, Non-Participating Professional Providers, any difference between the Non-Preferred Professional Provider's charge and the Carrier's payment shall be the personal responsibility of the Covered Person.

If the Carrier determines that services were performed during an emergency, the Covered Person will not be subject to the Coinsurance or other cost-sharing features ordinarily applicable to Covered Services rendered by Non-Preferred Professional Providers.

Once Covered Services are rendered by a Professional Provider, the Carrier will not honor a Covered Person's request not to pay for claims submitted by the Professional Provider. The Carrier will have no liability to any person because of its rejection of the request.

Ancillary Providers

Preferred Ancillary Providers

Preferred Ancillary Providers include members of the Personal Choice Network that have a contractual relationship with the Carrier for the provision of services or supplies to Covered Persons. Benefits will be provided as specified in the Schedule of Benefits for the provision of services or supplies provided to Covered Persons by Preferred Ancillary Providers. The Carrier will compensate Preferred Ancillary Providers in the Personal Choice Network in accordance with the contracts entered into between such Providers and the Carrier. No payment will be made directly to the Covered Person for Covered Services rendered by any Preferred Ancillary Provider.

Non-Preferred Ancillary Providers

Non-Preferred Ancillary Providers are not members of the Personal Choice Network. Benefits will be provided to the Covered Person at the Non-Preferred coinsurance level specified in the Schedule of Benefits. The Covered Person will be penalized by the application of a higher Coinsurance level and/or Deductible as detailed in the Schedule of Benefits.

Assignment of Benefits to Providers

The right of a Covered Person to receive benefit payments under this coverage is personal to the Covered Person and is not assignable in whole or in part to any person, Hospital, or other entity nor may benefits of this coverage be transferred, either before or after Covered Services are rendered. However, a Covered Person can assign benefit payments to the custodial parent of a Dependent covered under the Fund Contract, as required by law.

BLUECARD PPO PROGRAM

As a Covered Person under the Personal Choice health benefits program, the Carrier is able to provide access to the BlueCard PPO Program. If the Covered Person travels outside the Carrier's geographic service area and receives Covered Services from a Provider that is outside of the Personal Choice Network, the Covered Person still can receive

the Preferred level of benefits if the Provider participates in the BlueCard PPO Program. If precertification is required for the Covered Service, however, the Covered Person is responsible for ensuring that the Provider obtain all required certifications.

Under the Personal Choice coverage, "Preferred Provider" is defined to be a Facility Provider, Professional Provider or Ancillary Provider that is a member of the Personal Choice Network, authorized to perform specific Covered Services at the Preferred level of benefits. For purposes of giving a Covered Person access to the BlueCard PPO Program, a "Preferred Provider" is also a Facility Provider, Professional Provider or Ancillary Provider that is: (1) located outside of the Carrier's geographic area, (2) is authorized to perform specific Covered Services at the Preferred level of benefits, (3) has agreed to render Covered Services to Covered Persons at the Preferred level of benefits for a price or fee determined in advance under an agreement with another Blue Cross and Blue Shield Plan, and (4) does not have such an agreement with the Carrier. This type of Preferred Provider is referred to as a "BlueCard PPO Provider".

The calculation of a Covered Person's liability for Covered Services for claims incurred outside the geographic area served by QCC Insurance Company ("QCC") and processed through the BlueCard PPO Program typically will be at the lower of the provider's billed charges or the negotiated rate QCC pays the on-site Blue Cross and/or Blue Shield Plan.

The negotiated rate paid by QCC to the on-site Blue Cross and/or Blue Shield Plan for health care services provided through the BlueCard Program may represent either (i) the actual price paid on the claim or (ii) an estimated price that reflects adjusted aggregate payments expected to result from settlements or other non-claims transactions with all of the on-site Plan's health care providers or one or more particular providers or (iii) a discount from billed charges representing the on-site Plan's expected average savings for all of its providers or for a specified group of providers.

Plans using either the estimated price or average savings factor methods may prospectively adjust the estimated or average price to correct for over- or underestimation of past prices.

In addition, state statutes or rules require Blue Cross and/or Blue Shield Plans in a small number of states to use a basis for calculating a Covered Person's liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim. Thus, when Covered Persons receive Covered Services in these states, their liability for Covered Services will be calculated using these states' required methods.

DEDUCTIBLE

If you choose to utilize a Non-Preferred Provider, you must pay a portion of your covered medical expenses before the Carrier begins to pay for benefits. A Deductible must be met each Benefit Period before payment will be made for Non-Preferred Services. See the Schedule of Benefits section for the Deductible amount.

Expenses incurred for Non-Preferred Services in the last three (3) months of a Benefit Period which were applied to that year's Non-Preferred Deductible will be applied to the Deductible for the next Benefit Period.

No more than two times the individual Deductible under one Family Coverage must be satisfied in each Benefit Period. However, no family member may contribute more than the individual Deductible amount.

COINSURANCE

Coinsurance is a percentage of the Covered Expenses that must be paid by you or your covered Dependents; it is applied after the Deductible, if any, is met. Coinsurance is applied to most Covered Services when they are received from most Non-Preferred Providers. Refer to the Schedule of Benefits for specific Coinsurance amounts.

Limits on Coinsurance Liability

There is a Maximum placed on the amount of Coinsurance which you are required to pay each Benefit Period. This Maximum is called your "Out-of-Pocket Coinsurance Limit". See the Schedule of Benefits section for the Out-of-Pocket Coinsurance Limit amounts.

When the Non-Preferred Out-of-Pocket Limit is reached, the Carrier will pay 100% of the Covered Expenses for Non-Preferred services incurred during the balance of the Benefit Period. There is an individual Out-of-Pocket Limit and a family Out-of-Pocket Limit. In meeting the family Out-of-Pocket Limit, not more than two times the individual Out-of-

Pocket Limit amount must be satisfied by the members enrolled under one Family Coverage before the coinsurance is increased to 100% for Covered Services for the remainder of the Benefit Period. However, no Family member may contribute more than one individual amount toward the Family Out-of-Pocket Limit.

Out-of-Pocket expenses incurred for Non-Preferred Covered Services do not count toward the Preferred Out-of-Pocket Limit.

Inpatient and Outpatient Mental Health/Psychiatric services, your Deductible, if any, and any other co-payments and penalties do not count toward the Out-of-Pocket Limit.

LIFETIME MAXIMUM

There is a Lifetime Maximum for all Non-Preferred care. Benefits for Non-Preferred care will cease after benefits for Preferred and Non-Preferred care exceed the individual Non-Preferred Lifetime Maximum.

See the Schedule of Benefits for Lifetime Maximum amounts.

Amounts applied to the Covered Person's Lifetime Maximum are not restorable.

HOW TO FILE A CLAIM

You are never required to file a claim when Covered Services are provided by Preferred Providers. When you receive care from a Non-Preferred Provider, you will need to file a claim to receive benefits. If you do not have a claim form, call Member Services at the number listed on the back of your Identification Card, and a claim form will be sent to you. Fill out the claim form and return it with your itemized bills to QCC Insurance Company at the address listed on the claim form no later than 20 days after completion of the Covered Services. The claim should include the date and information required by the Carrier to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

If it was not possible to file the claim within the 20-day period, your benefits will not be reduced, but in no event will the plan be required to accept the claim more than two years after the end of the Benefit Period in which the Covered Services are rendered.

ELIGIBILITY UNDER THE PLAN

Who Is Eligible and When?

Effective Date: The date the Fund agrees that all Eligible Persons may apply and become covered for the benefits as set forth in the Fund Contract and described in this booklet/certificate. If a person becomes an eligible person after the Fund's Contract Date, that date becomes the Effective Date.

ELIGIBLE PERSON

You are eligible to be covered under this Personal Choice Plan if you are determined by the Fund as eligible to apply for coverage and sign the Application.

Eligibility shall not be affected by your physical condition and determination of eligibility for the coverage by the Employer shall be final and binding.

ELIGIBLE DEPENDENT

Your family is eligible for coverage (Dependent coverage) when you are eligible for Member coverage. An Eligible Dependent is defined as your spouse under a legally valid existing marriage, your unmarried child(ren), including any stepchild, legally adopted child, a child placed for adoption or any child whose coverage is your responsibility under the terms of a qualified release or court order. The limiting age for covered, unmarried children is to the end of the month in which they reach age 19; or if a student is enrolled full-time in an Accredited Educational Institution, the limiting age is not beyond the end of the month in which they reach age 23.

Eligibility will be continued past the limiting age for unmarried children, regardless of age, who are incapable of self-support because of mental or physical incapacitation and who are dependent on you for over half of their support. The Plan may require proof of your eligibility under the prior carrier's plan and also from time to time under this Plan.

The newborn child(ren) of you or your Dependent shall be entitled to the benefits provided by the Plan from the date of birth for a period of 31 days. Coverage of newborn children within such 31 days shall include care that is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. To be eligible for Dependent coverage beyond the 31 day period, you must enroll the newborn child within such 31 days. To continue coverage beyond 31 days for a newborn child, who does not otherwise qualify for coverage as a Dependent, you must apply within 31 days after the birth of the newborn and the appropriate rate must be paid when billed.

A newly acquired Dependent shall be eligible for coverage under the Plan on the date the Dependent is acquired provided that you apply to the Carrier for addition of the Dependent within 31 days after the Dependent is acquired and you make timely payment of the appropriate rate. If Application is made later than 31 days after the Dependent is acquired, coverage shall become effective on the first billing date following 30 days after your Application is accepted by the Carrier.

A Dependent child of a custodial parent covered under the Fund Contract may be enrolled under the terms of a qualified medical release or court order, as required by law.

No Dependent may be eligible for coverage as a Dependent of more than one Member of the Enrolled Fund. No individual may be eligible for coverage hereunder as a Member and as a Dependent of a Member at the same time.

YOUR PERSONAL CHOICE BENEFITS

All Inpatient Hospital Admissions, other than a maternity admission or an admission for a Medical Emergency, and certain other services as described in this section below must receive precertification in accordance with the requirements contained in the Managed Care section of this booklet/certificate. Admissions for a Medical Emergency must be reviewed within two (2) business days of the admission, or as soon as reasonably possible, as determined by the Carrier.

The services described below may be provided by either a Preferred or Non-Preferred Provider. However, the Covered Person will maximize the benefits available when services are provided by a Provider that belongs to the Personal Choice Network (a Preferred or "In-Network" Provider) and has a contract with the Carrier to provide services and supplies to the Covered Person. Not all Preferred Providers are authorized by the Carrier to be Preferred Providers for all services. Such services include but are not limited to, outpatient radiology services and certain outpatient laboratory testing services. The Personal Choice Network directory lists those Providers that belong to the network. It also lists those Preferred Providers that are authorized by the Carrier to perform only selected services at the Preferred level of benefits.

The Covered Person will be held harmless for out of network differentials if:

- (a) a Preferred Provider in the Personal Choice Network fails to provide written notice to the Covered Person of the Provider's Non-Preferred status for outpatient radiology or laboratory services, and that Provider performs such services; or
- (b) a Preferred Provider in the Personal Choice Network provides a written order for outpatient radiology or laboratory services to be performed by a Preferred Provider that has Non-Preferred status for those services, and that Provider performs such services.

INPATIENT SERVICES - All Inpatient Admissions, other than an emergency admission, must be precertified by the Carrier in accordance with the requirements contained in the Managed Care section of this booklet/certificate. Emergency admissions must be reviewed within 2 business days of the admission or as soon as reasonably possible. A concurrent review is required for any continued length of stay beyond what has been Pre-Certified by the Carrier.

HOSPITAL SERVICES: ROOM AND BOARD

Benefits will be paid for general nursing care and such other services as are covered by the Hospital's regular charges for accommodations in the following:

- a) an average semi-private room, as designated by the Hospital; or a private room, when designated by the Carrier as semi-private for the purposes of this coverage in Hospitals having primarily private rooms;
- b) a private room, when Medically Appropriate;
- c) a Special Care Unit, such as Intensive or Coronary Care, when such a designated unit with concentrated facilities, equipment and supportive services is required to provide an intensive level of care for a critically ill patient;
- d) a bed in a general ward; and
- e) nursery facilities.

Benefits are provided for up to the number of days specified in the Schedule of Benefits.

In computing the number of days of benefits, the day of admission, but not the date of discharge shall be counted. If the Covered Person is admitted and discharged on the same day, it shall be counted as one day.

Days available under this coverage shall be allowed only during uninterrupted stays in a Hospital. Benefits shall not be provided: (1) during the absence of a Covered Person who interrupts his stay and remains past midnight of the day on which the interruption occurred; or (2) after the discharge hour that the Covered Person's attending Physician has recommended that further Inpatient care is not required.

HOSPITAL SERVICES: ANCILLARY SERVICES

Benefits are payable for all ancillary services usually provided and billed for by Hospitals (except for personal convenience items) including but not limited to the following:

- a) meals, including special meals or dietary services as required by the patient's condition;
- b) use of operating, delivery, recovery, or other specialty service rooms and any equipment or supplies therein;
- c) casts, surgical dressings, and supplies, devices or appliances surgically inserted within the body;
- d) oxygen and oxygen therapy;
- e) administration of blood and blood plasma, including the processing of blood from donors, but excluding the blood or blood plasma, except as may be provided within this coverage;
- f) anesthesia when administered by a Hospital employee, and the supplies and use of anesthetic equipment;
- g) Physical Therapy, Cardiac Rehabilitation Therapy, Respiratory Therapy, hydrotherapy, Speech Therapy, and/or Occupational Therapy when administered by a person who is appropriately licensed and authorized to perform such services;
- h) Radiation Therapy;
- i) Chemotherapy;
- j) all drugs and medications (including intravenous injections and solutions) for use while in the Hospital and which are released for general use and are commercially available to Hospitals;
- k) use of Special Care Units, including but not limited to, Intensive or Coronary Care; and
- l) Preadmission testing.

Subject to the Exclusions, conditions and limitations of this coverage, a Covered Person is entitled to benefits for Covered Services when: (1) deemed Medically Necessary and/or Medically Appropriate and (2) billed for by a Provider.

EMERGENCY CARE SERVICES

Benefits for Emergency Care Services are provided by the Carrier at the Preferred level of benefits, regardless of whether the patient is treated by a Preferred or Non-Preferred Provider. If Emergency Services are required, whether the Covered Person is located in or outside the Personal Choice Network service area, call 911 or seek treatment immediately at the emergency department of the closest Hospital.

Outpatient services and supplies provided by a Hospital or Facility Provider and/or Professional Provider for emergency treatment of: (1) traumatic bodily injury resulting from an accident shall be covered if services are performed within two (2) days of the date the accident occurred. Follow-up care provided in a Medically Appropriate setting shall also be covered if received within 14 days of the initial treatment, as specified above, for the Accidental Injury; or (2) a medical condition with acute symptoms that would result in requiring immediate Medical Care shall be covered if services are performed within two (2) days of the Medical Emergency. Medical Emergency shall include heart attacks, loss of consciousness or respiration, cardiovascular accident, convulsions or other such acute medical conditions as determined by the Carrier. Follow-up care in a Medically Appropriate setting shall also be covered if received within 14 days of the initial treatment, as specified above, of the Medical Emergency.

Should any dispute arise as to whether an emergency condition existed, the determination by the Carrier shall be final.

SURGICAL SERVICES

Surgery benefits will be provided for services rendered by a Professional Provider and/or Facility Provider for the treatment of disease or injury. Separate payment will not be made for Inpatient preoperative care or all postoperative care normally provided by the surgeon as part of the surgical procedure. Also covered is (1) the 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 wide clefts affecting the alveolus; and (2) coverage for the

following when performed subsequent to mastectomy: surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. Coverage is also provided for: (a) the initial and subsequent insertion or removal of prosthetic devices to replace the removed breast or portions thereof; and (b) the treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Failure to obtain preprocedure certification for Non-Preferred Services will result in a 20% reduction of the benefits payable for surgical services.

Covered surgical procedures shall include routine neonatal circumcisions, any voluntary surgical procedure for sterilization, any surgery performed for the reversal of a sterilization procedure.

- **Hospital Admission for Dental Procedures or Dental Surgery**

Benefits will be payable for a Hospital admission in connection with dental procedures or Surgery only when the Covered Person has an existing non-dental physical disorder or condition and hospitalization is Medically Appropriate/ Medically Necessary to ensure the patient's health. Dental procedures or Surgery performed during such a confinement will only be covered for the services described below under "Oral Surgery" and "Dental Services Related to Accidental Injury".

- **Oral Surgery**

Dental or oral surgery rendered by a Professional Provider and/or Facility Provider will be a Covered Expense under this program only for surgical removal of impacted teeth which are partially or completely covered by bone.

- **Dental Services Related to Accidental Injury**

Dental Services rendered by a Professional Provider and/or a Facility Provider which are required as a result of Accidental Injury to the jaws, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered an Accidental Injury.

- **Assistant at Surgery**

Services for a Covered Person by an assistant surgeon who actively assists the operating surgeon in the performance of covered Surgery.

The condition of the Covered Person or the type of Surgery must require the active assistance of an assistant surgeon as determined by the Carrier. Surgical assistance is not covered when performed by a Professional Provider who himself performs and bills for another surgical procedure during the same operative session.

- **Anesthesia**

Administration of Anesthesia in connection with the performance of Covered Services when rendered by or under the direct supervision of a Professional Provider other than the surgeon, assistant surgeon or attending Professional Provider.

- **Second Surgical Opinion (Voluntary)**

Consultations for Surgery to determine the Medical Necessity of an elective surgical procedure. Elective Surgery is that Surgery which is not of an emergency or life threatening nature.

Such Covered Services must be performed and billed by a Professional Provider other than the one who initially recommended performing the Surgery. One additional consultation, as a third opinion, is eligible in cases where the second opinion disagrees with the first recommendation. In such instances the Covered Person 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 CARE

Medical Care rendered by the Professional Provider in charge of the case to a Covered Person who is an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility for a condition not related to Surgery, pregnancy, Radiation Therapy, or Mental Illness, except as specifically provided. Such care includes Inpatient intensive Medical Care rendered to a Covered Person whose condition requires a Professional Provider's constant attendance and treatment for a prolonged period of time.

- a) **Concurrent Care**

Services rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider who is not in charge of the case but whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the Covered Person, standby services, routine preoperative physical examinations or Medical Care routinely performed in the pre-or post-operative or pre-or post-natal periods or Medical Care required by a Facility Provider's rules and regulations.

- b) **Consultations**

Consultation services when rendered to an Inpatient in a Hospital, Rehabilitation Hospital or Skilled Nursing Facility by a Professional Provider at the request of the attending Professional Provider. Consultations do not include staff consultations which are required by Facility Provider's rules and regulations.

Benefits are limited to one (1) consultation per consultant during any inpatient confinement.

DIAGNOSTIC SERVICES

The following Diagnostic Services when ordered by a Professional Provider and billed by a Professional Provider, and/or a Facility Provider:

- a. Diagnostic X-ray, consisting of radiology, ultrasound, and nuclear medicine;
- b. Diagnostic laboratory and pathology tests.
- c. Diagnostic medical procedures consisting of ECG, EEG, and other diagnostic medical procedures approved by the Carrier.
- d. Allergy testing, consisting of percutaneous, intracutaneous and patch tests and immunotherapy.

Preprocedure certification is required for the following Non-Preferred diagnostic procedures: Operative and Diagnostic Endoscopies, MRI and CAT Scan, as described in the Managed Care Section. Failure to pre-certify these Non-Preferred Services will result in a 20% reduction in benefits.

The Carrier reserves the right to modify the diagnostic procedures that are subject to precertification after written notice has been given to the Fund.

THERAPY SERVICES

Benefits shall be provided, subject to the Benefit Period Maximums specified in the Schedule of Benefits, for the following services prescribed by a Physician and performed by a Professional Provider, a registered, licensed therapist, and/or Facility Provider, which are used in treatment of an illness or injury to promote recovery of the Covered Person.

Chemotherapy

Chemotherapy means the treatment of malignant disease by chemical or biological antineoplastic agents, monoclonal antibodies, bone marrow stimulants, antiemetic and other related biotech products. Such chemotherapeutic agents are eligible if administered intravenously or intramuscularly (through intra-arterial injection, infusion, perfusion or subcutaneous, intracavitary and oral routes).

The cost of drugs, approved by the Federal Food and Drug Administration and only for those uses for which such drugs have been specifically approved by the Federal Food and Drug Administration (FDA) as antineoplastic agents is covered, provided they are administered as described in this paragraph.

Dialysis

The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body by hemodialysis, peritoneal dialysis, hemoperfusion, chronic ambulatory peritoneal dialysis (CAPD), or continuous cyclical peritoneal dialysis (CCPD).

Benefits will not be provided to the extent that benefits are payable by Medicare for persons who are Medicare eligible on the basis of end stage renal disease (ESRD) and for whom Medicare must pay as primary carrier.

Radiation Therapy

The treatment of disease by X-ray, radium, or radioactive isotopes, or other radioactive substances regardless of the method of delivery, including the cost of radioactive materials supplied and billed by the Provider.

Physical Therapy

Includes treatment by physical means, heat, hydrotherapy or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.

Cardiac Rehabilitation Therapy

Refers to a medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise. Such therapy is covered for a patient recovering from myocardial infarction or a coronary bypass procedure, or who has been diagnosed with coronary disease, angina pectoris, valvular heart disease, exercise triggered cardiac arrhythmia or such other conditions as determined by the Carrier. Benefits are provided up to the number of visits specified in the Schedule of Benefits.

Respiratory Therapy

Includes the introduction of dry or moist gases into the lungs for treatment purposes. Coverage will also include services by a respiratory therapist.

Occupational Therapy

Includes 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. Coverage will also include services rendered by a registered, licensed occupational therapist.

Speech Therapy

Includes treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital anomalies, or previous therapeutic processes. Coverage will also include services by a speech therapist

Pulmonary Rehabilitation Therapy

Includes treatment through a multidisciplinary program which combines Physical Therapy with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status for Chronic Obstructive Pulmonary Disease (COPD). COPD may include, but is not limited to, diagnosis such as emphysema, chronic bronchitis, asthmatic bronchitis, pre-lung transplant and cystic fibrosis. Benefits are provided up to the number of sessions specified in the Schedule of Benefits.

Infusion Therapy

Treatment includes, but is not limited to, infusion or inhalation, parenteral and Enteral Nutrition, antibiotic therapy, pain management and hydration therapy.

Preprocedure certification is required for the following Therapy Services: Physical, Speech, Occupational, Cardiac Rehabilitation, Respiratory, Pulmonary Rehabilitation and Infusion Therapies, as described in the Managed Care section of this booklet/certificate. Failure to pre-certify Non-Preferred Services will result in a 20% reduction in benefits payable for these services.

RESTORATIVE SERVICES

Benefits shall be provided for Restorative Services when performed by a Professional Provider in order to restore loss of function of a body part. Restorative Services are any services, other than those specifically detailed above under THERAPY SERVICES, provided in accordance with a specific plan of treatment related to the Covered Person's condition which generally involve neuromuscular training as a course of treatments over weeks or months. Examples of Restorative Services include, but are not limited to, manipulative treatment of functional loss from back disorder, therapy treatment of functional loss following foot surgery, and treatment of oculomotor dysfunction.

Following a determination by a Professional Provider that restorative services are required, a specific plan of treatment must be precertified by the Carrier. Failure to pre-certify Non-Preferred Services will result in a 20% reduction in the benefits payable for these services.

MATERNITY SERVICES

Obstetrical/Maternity Care

Services rendered in the care and management of a pregnancy for a Member or spouse are a Covered Expense under this program as specified in the Schedule of Benefits.

Precertification of maternity care should occur within one month of the first prenatal visit to your physician or midwife. Benefits are payable for: (1) facility services provided by a Hospital or Birth Center and (2) professional services performed by a Professional Provider or certified nurse midwife. Benefits payable for a delivery shall include pre-and post-natal care. Maternity care Inpatient benefits will be provided for 48 hours for vaginal deliveries and 96 hours for cesarean deliveries, except where otherwise approved by the Carrier. In the event of early post-partum discharge, benefits are provided for home health care as provided for in the subsection entitled HOME HEALTH CARE.

Elective Abortions

Facility services provided by a Hospital or Birth Center and services performed by a Professional Provider for the voluntary termination of a pregnancy by a Member or a spouse are a Covered Expense under this program.

Newborn Care

The newborn child of a Covered Person shall be entitled to benefits provided by this program from the date of birth up to a maximum of 31 days. Such coverage within the 31 days shall include care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Coverage for a newborn may be continued beyond 31 days under conditions specified in the "ELIGIBILITY UNDER THE PLAN" section of the booklet/ certificate.

SKILLED NURSING CARE FACILITY

Benefits are provided for a Skilled Nursing Care Facility, when Medically Appropriate as determined by the Carrier, up to the Maximum days specified in the Schedule of Benefits. The Covered Person must require treatment by skilled nursing personnel which can be provided only on an Inpatient basis in a Skilled Nursing Care Facility. For maximum benefits, admission to a Skilled Nursing Care must be pre-certified as an Inpatient admission in accordance with the Managed Care section of this booklet/certificate.

Medically Necessary Professional Provider visits in a Skilled Nursing Facility are provided as shown in the Schedule of Benefits.

No benefits are payable:

- when confinement in a Skilled Nursing Facility is intended solely to assist the Covered Person with the activities of daily living or to provide an institutional environment for the convenience of a Covered Person;
- for the treatment of alcohol and drug addiction, and Mental Illness; or
- after the Covered Person has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine custodial care.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES

Precertification is required on the rental of any Durable Medical Equipment and the purchase of all Durable Medical Equipment and Prosthetic devices that exceed the amount shown on the Schedule of Benefits.

Durable Medical Equipment

The rental (but not to exceed the total allowance of purchase) or, at the option of the Carrier, the purchase of Durable Medical Equipment when prescribed by a Professional Provider and required for therapeutic use, when determined to be Medically Appropriate/Medically Necessary by the Carrier.

Prosthetic Devices

Expenses incurred for prosthetic devices for an illness or injury.

Expenses for prosthetic devices are subject to medical review by the Carrier to determine eligibility and Medical Appropriateness/Medical Necessity.

Such expenses may include, but not be limited to:

- a) the purchase, fitting, necessary adjustments and repairs of prosthetic devices and supplies which replace all or part of an absent body organ including contiguous tissue or which replace all or part of the function of an inoperative or malfunctioning body organ; and
- b) prosthetic devices inserted during reconstructive surgery incident to mastectomy when performed subsequent to the mastectomy; and
- c) eyeglasses or contact lenses which perform the function of a human lens lost as a result of ocular Surgery (i.e. cataract Surgery) or injury; pinhole glasses prescribed for use after Surgery for detached retina; lenses prescribed in lieu of Surgery for the following:
 - 1) contact lenses used for treatment of infantile glaucoma;
 - 2) corneal or scleral lenses prescribed in connection with the treatment of keratoconus;
 - 3) scleral lenses prescribed to retain moisture in cases where normal tearing is not present or adequate; and
 - 4) corneal or scleral lenses to reduce a corneal irregularity other than astigmatism (for example, B & L Griffon Softcon Bandage Type Lenses).

Benefits are not payable for wigs, or eyeglasses except as specified in Item (c) above.

Benefits for replacement of a prosthetic device will be provided only for a Dependent child due to the normal growth process when Medically Necessary.

HOME HEALTH CARE

Benefits will be provided for the services listed below when performed by a licensed Home Health Care Agency. Home Health Care services must be pre-certified in accordance with the provisions set forth in the Managed Care section of this booklet/certificate.

Professional services of appropriately licensed and certified individuals;

Intermittent Skilled Nursing Care;

Physical Therapy;

Speech Therapy;

Well mother/well baby care following release from an inpatient maternity stay.

Care within 48 hours following release from an Inpatient admission when the discharge occurs within 48 hours following a mastectomy.

With respect to well mother/well baby care following early release from an inpatient maternity stay, Home Health Care services must be provided within 48 hours if discharge occurs earlier than 48 hours of a vaginal delivery or 96 hours of a cesarean delivery. No Deductible, Copayment or Coinsurance shall apply to these benefits when they are provided after an early discharge from the inpatient maternity stay.

Benefits are also provided for certain other medical services and supplies when provided along with a primary service. Such other services and supplies include occupational therapy, medical social services, home health aides in conjunction with skilled services and other services which may be approved by the Carrier.

Home health care benefits will be provided only when prescribed by the Covered Person's attending Physician in a written Plan of Treatment and approved by the Carrier as Medically Appropriate.

Precertification must be performed in accordance with the Managed Care section of the booklet/certificate. Failure

to pre-certify Non-Preferred Services will result in a 20% reduction in benefits payable.

There is no requirement that the Covered Person be previously confined in a Hospital or Skilled Nursing Facility prior to receiving home health care.

With the exception of home health care provided to a Covered Person immediately following an Inpatient release for maternity care, the Covered Person must be homebound in order to be eligible to receive home health care benefits. This means that leaving the home could be harmful to such person, would involve a considerable and taxing effort, and that the Covered Person is unable to use transportation without another's assistance.

Exclusions

No Home Health Care benefits will be provided for services and supplies in connection with home health services for the following:

- custodial services, food, housing, homemaker services, home delivered meals and supplementary dietary assistance;
- rental or purchase of Durable Medical Equipment;
- rental or purchase of medical appliances (e.g. braces) and prosthetic devices (e.g., artificial limbs); supportive environmental materials and equipment, such as handrails, ramps, telephones, air conditioners and similar services, appliances and devices;
- prescription drugs;
- services provided by a member of the patient's Immediate Family or the Immediate family of the patient's spouse;
- patient's transportation, including services provided by voluntary ambulance associations for which the patient is not obligated to pay;
- emergency or non-emergency Ambulance services;
- visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional Occupational Therapy and/or social services;
- services provided to individuals (other than a Covered Person released from an inpatient maternity stay), who are not essentially homebound for medical reasons; and
- visits by any Provider personnel solely for the purpose of assessing an individual's condition and determining whether or not the individual requires and qualifies for home health services and will or will not be provided services by the Provider.

HOSPICE SERVICES

When the Covered Person's attending Physician certifies that the Covered Person has a terminal illness with a medical prognosis of six (6) months or less and when the Covered Person elects to receive care primarily to relieve pain, the Covered Person shall be eligible for Hospice benefits.

When Hospice Care is provided primarily in the home, such care on a short-term Inpatient basis in a Medicare certified Skilled Nursing Facility will also be covered when the Hospice considers such care necessary to relieve primary caregivers in the patient's home. Up to seven (7) days of such care every six (6) months will be covered. Benefits are subject to precertification in accordance with the provisions set forth in the Managed Care section of this booklet/certificate. Failure to pre-certify Non-Preferred Services will result in a 20% reduction in benefits payable. Benefits for Covered Hospice Services shall be provided until the earlier of patient's death or discharge from the Hospice. These benefits are in addition to and not in lieu of any other benefits in this program.

Special Exclusions

The Hospice Care program must deliver Hospice Care in accordance with a treatment plan approved by and periodically reviewed by the Carrier.

No Hospice Care benefits will be provided for:

1. services and supplies for which there is no charge;
2. research studies directed to life lengthening methods of treatment;
3. services or expenses incurred in regard to the patient's personal, legal and financial affairs (such as preparation and execution of a will or other dispositions of personal and real property);
4. care provided by family members, relatives, and friends; and
5. Private Duty Nursing care.

AMBULANCE

Ambulance services, which are Medically Appropriate/Medically Necessary as determined by the Carrier, for local transportation in a specially designed and equipped vehicle used only to transport the sick or injured are a Covered Expense. All Non-Preferred, non-emergency ambulance services must be pre-certified in accordance with the provisions set forth in the Managed Care section of this booklet/certificate. The Ambulance must be transporting the Covered Person:

- a. from a Covered Person's home or the scene of an accident or Medical Emergency to the nearest Hospital;
- b. between Hospital and Skilled Nursing Facility or between Hospitals.
- c. If there is no Hospital in the local area that can provide services Medically Necessary/Medically Appropriate for the Covered Person's condition, then ambulance service means transportation to the closest Hospital outside the local area that can provide the necessary service.
- d. Air or sea ambulance transportation benefits are payable only if the Carrier determines that the patient's condition, and the distance to the nearest facility able to treat the patient's condition, justify the use of air instead of another means of transportation.

Failure to pre-certify Non-Preferred, Non-Emergency services will result in a 20% reduction in benefits payable for these services.

TRANSPLANT SERVICES

When a Covered Person is the recipient of transplanted human organs, marrow, or tissues, benefits are provided for all Inpatient and Outpatient transplants which are beyond the Experimental or Investigative stage. Inpatient and Outpatient transplants require precertification with the following exceptions: transplantation of cornea or skin.

Benefits are also provided for those services to the Covered Person which are directly and specifically related to the covered transplantation. This includes services for the examination of such transplanted organs, marrow, or tissue and the processing of Blood provided to a Covered Person.

- (a) When both the recipient and the donor are Covered Persons, each is entitled to the benefits of this Contract.
- (b) When only the recipient is a Covered Person, both the donor and the recipient are entitled to the benefits of this Contract. The donor benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, or coverage by the Carrier or any government program. Benefits provided to the donor will be charged against the recipient's coverage under this Contract.
- (c) When only the donor is a Covered Person, the donor is entitled to the benefits of the Contract. The benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or coverage by the Carrier or any government program available to the recipient. No benefits will be provided to the non-Covered Person transplant recipient.
- (d) If any organ or tissue is sold rather than donated to the Covered Person recipient, no benefits will be payable for the purchase price of such organ or tissue.

Failure to pre-certify Non-Preferred, Inpatient transplants will result in a \$1,000 reduction in benefits payable for these services.

Failure to pre-certify Non-Preferred, Outpatient transplants will result in a 20% reduction in benefits payable for these services.

OUTPATIENT PRIVATE DUTY NURSING SERVICES

Benefits will be provided as specified in the Schedule of Benefits for Outpatient services for Private Duty Nursing performed by a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) when ordered by a Physician. All nursing services must be Medically Appropriate/Medically Necessary as determined by the Carrier and pre-certified in accordance with the provisions set forth in the Managed Care section of this booklet/certificate.

Benefits are not payable for:

- (a) nursing care which is primarily custodial in nature; such as care that primarily consists of: bathing, feeding, exercising, homemaking, moving the patient, giving oral medication;
- (b) services provided by a nurse who ordinarily resides in the Covered Person's home or is a member of the Covered Person's immediate family; and
- (c) services provided by a home health aide or a nurse's aide.

PRIMARY CARE SERVICES

Home and Office Visits, Outpatient Consultations

Medical care visits for the examination, diagnosis and treatment of an illness or injury.

Preventive Pediatric and Adult Care

"Preventive Services" generally describes health care services performed to catch the early-warning signs of health problems. These services are performed when you have no symptoms of disease. Services performed to treat an illness or disease are not covered as Preventive Care under the Primary Care Services section of this booklet/certificate.

Preventive Pediatric Care -- Well baby care including routine Physician examinations and routine diagnostic tests. Benefits are limited to Covered Dependents under 18 years of age in accordance with the schedule shown below.

Benefits are provided for services when the service is received during the ages listed below. When a range is given, (i.e., 2-3 months) the dash indicates that coverage is available for one service from 2 months through 3 months of age.

Routine History, Physical Examination: Generally includes a medical history, height and weight measurement, physical examination, and counseling.

24 exams up to age 17 -- one exam during each of the following age groupings:

0-1 month	15-17 months	6 years	12 years
2-3 months	18-24 months	7 years	13 years
4-5 months	2 years	8 years	14 years
6-8 months	3 years	9 years	15 years
9-11 months	4 years	10 years	16 years
12-14 months	5 years	11 years	17 years

Blood Lead Screening - A blood test which detects elevated lead levels in the blood. Children are covered for:

- One test between 9-12 months
- One test at 24 months

Urinalysis - This test detects numerous abnormalities. Children are covered for:

- One test every year from birth through age 17

Hemoglobin/Hematocrit - A blood test which measures the size, shape, number and content of red blood cells. Children are covered for:

- one service from birth-12 months
- one service from age 1-4 years
- one service from age 5-12 years
- one service from age 14-17 years

Rubella Titer Test - The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present, the rubella immunization should be given. The rubella titer test is recommended when it is unsure whether the child has ever been immunized. Children are covered for one test and immunization from ages 11-17 years

Pediatric Immunizations -- as determined by the Department of Health, conform with the Standards of the (Advisory Committee on Immunization Practices of the Center for Disease Control) U.S. Department of Health and Human Services. Benefits are limited to you and your spouse until you reach age 21 and to Dependent children. This benefit is not subject to a deductible or coinsurance.

Routine Gynecological Examination and Pap Smears -- Female Covered Persons are covered for one annual gynecological examination, including a pelvic examination and clinical breast examination, and routine Pap smears in accordance with the recommendations of the American College of Obstetricians and Gynecologists. This benefit is not subject to a deductible or coinsurance.

Mammograms - Coverage is provided for screening and diagnostic mammograms. Benefits for mammography screening are payable only if performed by a mammography service provider who is properly certified by the Department of Health in accordance with the Mammography Quality Assurance Act of 1992. Deductibles do not apply to this benefit.

Adult Preventive Care -- periodic well-person routine immunizations and examinations, including physical examination, complete medical history, plus necessary Diagnostic Services. Benefits are limited to Covered Persons 18 years of age and older in accordance with the following schedule:

Routine History, Physical Examination: Generally includes a medical history, height and weight measurement, physical examination, and counseling.

One exam every year at ages 18, 19, 20, 21
One exam every three years from age 22-39
One exam every year, beginning at age 40

Fecal Occult Blood Test - A test for the presence of blood in the feces which is an early indicator of colorectal cancer.

One test per year, beginning at age 50

Blood Cholesterol Test - A blood test which measures the total serum cholesterol level. High blood cholesterol is one of the risk factors that leads to coronary artery disease.

One test every four years from age 18-39
One test every year, beginning at age 40

Flexible Sigmoidoscopy - This test detects colorectal cancer by use of a flexible fiberoptic sigmoidoscope.

One test every three years, beginning at age 50.

Prostatic Specific Antigen (PSA) - A blood test which may be used to detect tumors of the prostate.

One test every year, beginning at age 50.

Urinalysis - This test detects numerous abnormalities.

One test every year, beginning at age 18.

Complete Blood Count (CBC) - A blood test which checks the red and white blood cell levels, hemoglobin and hematocrit.

One test every year at ages 18, 19, 20, 21
One test every three years from age 22-39
One test every year, beginning at age 40

Thyroid Function Test - This blood test detects hyperthyroidism and hypothyroidism.

One test every year, beginning at age 18.

Adult Tetanus Toxoid (TD) - An immunization which provides immunity against tetanus and diphtheria.

One service every ten years from age 18

Rubella Titer Test and Rubella Immunization - The rubella titer blood test checks for the presence of rubella antibodies. If no antibodies are present the rubella immunization should be given. The rubella titer test is recommended when it is unsure whether the adult has ever been immunized.

One test and immunization from age 18-49

Influenza Vaccine - A vaccine against influenza type A and B viruses.

One vaccine every year, beginning at age 18

Varicella Vaccine - Recommended for women of childbearing age who previously have not been exposed to the chicken pox virus.

Immunization for women ages 18-49

Pneumococcal Vaccine - A vaccine against pneumococcal disease. Pneumococcal disease may cause pneumonia and other infections such as meningitis and bronchitis.

One vaccine every five years, beginning at age 64

Lyme Vaccine – A vaccine to aid in the prevention of Lyme Disease.

One series of three injections administered within a 12 month period between the ages of 18-70.

Benefits are also payable for certain immunizations provided to Covered Persons determined to be at “high risk” as determined by the Carrier.

Therapeutic Injections

Therapeutic injections required in the treatment of an injury or illness.

Allergy Injections

Benefits are provided for allergy extracts and allergy injections.

The Carrier periodically reviews the schedule of covered services based on recommendations from organizations such as The American Academy of Pediatrics, The American College of Physicians, the U.S. Preventive Services Task Force and The American Cancer Society. Accordingly, the frequency and eligibility of services is subject to change. Therefore, the Carrier reserves the right to modify this schedule from time to time.

OUTPATIENT DIABETIC EDUCATION PROGRAM

Benefits are provided for diabetes Outpatient self-management training and education, including medical nutrition, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes when prescribed by a Professional Provider legally authorized to prescribe such items under law.

The attending Physician must certify that a Covered Person requires diabetic education on an Outpatient basis under the following circumstances: (1) upon the initial diagnosis of diabetes; (2) a significant change in the patient’s symptoms or condition; or (3) the introduction of new medication or a therapeutic process in the treatment or management of the patient’s symptoms or condition.

Outpatient diabetic education services will be covered when provided by a Preferred Facility Provider or a Preferred Ancillary Provider. The diabetic education program must be conducted under the supervision of a licensed health care professional with expertise in diabetes, and subject to the requirements of the Carrier. These requirements are based on the certification programs for outpatient diabetic education developed by the American Diabetes Association and the Pennsylvania Department of Health.

Covered services include Outpatient sessions that include, but may not be limited to, the following information:

- initial assessment of the patient's needs;
- family involvement and/or social support;
- psychological adjustment for the patient;
- general facts/overview on diabetes;
- nutrition including its impact on blood glucose levels;
- exercise and activity;
- medications;
- monitoring and use of the monitoring results;
- prevention and treatment of complications for chronic diabetes, (i.e., foot, skin and eye care);
- use of community resources; and
- pregnancy and gestational diabetes, if applicable.

BLOOD

Benefits shall be payable for the administration of Blood and Blood processing from donors. Benefits shall be payable for autologous Blood drawing, storage or transfusion - i.e., an individual having his own Blood drawn and stored for personal use, such as self-donation in advance of planned Surgery.

Benefits shall be payable for whole Blood, Blood plasma and Blood derivatives, which are not classified as drugs in the official formularies and which have not been replaced by a donor.

MEDICAL FOODS AND NUTRITIONAL FORMULAS

Benefits shall be payable for Medical Foods when provided for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. Coverage is provided when administered on an outpatient basis either orally or through a tube. Benefits are exempt from Deductible requirements.

Benefits are also payable for Nutritional Formulas when: (1) they are the sole source of nutrition for an individual (more than 75% of estimated basal caloric requirement) and the Nutritional Formula is given by way of a tube into the alimentary tract, or (2) the Nutritional Formula is the sole source of nutrition (more than 75% of estimated basal caloric requirement) for an infant or child suffering from Severe Systemic Protein Allergy, refractory to treatment with standard milk or soy protein formulas and casein hydrolyzed formulas.

Benefits are payable for Medical Foods and Nutritional Formulas when provided through a Durable Medical Equipment Supplier or in connection with Infusion Therapy as provided for in this coverage.

DIABETIC EQUIPMENT AND SUPPLIES

Benefits shall be provided, subject to any applicable Deductible, Copayment and/or Coinsurance or precertification requirements applicable to Durable Medical Equipment benefits. If your Fund plan provides coverage for prescription drugs through an endorsement to the Fund Contract, Diabetic Equipment and Supplies, including insulin and oral agents, may be purchased at a pharmacy, subject to the cost-sharing arrangements applicable to the prescription drug coverage.

1. Diabetic Equipment
 - (a) blood glucose monitors*;
 - (b) insulin pumps*;
 - (c) insulin infusion devices*;
 - (d) orthotics and podiatric appliances for the prevention of complications associated with diabetes*.

*Precertification is required for the purchase of equipment that exceeds \$100 of the billed amount. The applicable Deductible, Copayment and/or Coinsurance amounts will apply to this benefit.

2. Diabetic Supplies

- (a) blood testing strips;
- (b) visual reading and urine test strips;
- (c) **insulin and insulin analogs;
- (d) injection aids;
- (e) insulin syringes;
- (f) lancets and lancet devices;
- (g) monitor supplies;
- (h) **pharmacological agents for controlling blood sugar levels; and
- (i) glucagon emergency kits.

**If your Fund plan does not provide coverage for prescription drugs, insulin and oral agents are covered as provided under the following paragraph.

WHAT IS NOT COVERED

Except as specifically provided in this booklet/certificate, no benefits will be provided for services, supplies or charges:

- Which are not Medically Necessary/Medically Appropriate as determined by the Carrier for the diagnosis or treatment of illness or injury;
- Which are Experimental or Investigative in nature;
- Which were Incurred prior to the Covered Person's Effective Date of coverage;
- Which were or are Incurred after the date of termination of the Covered Person's coverage except as provided in the General Provisions section of this booklet/certificate;
- For any loss sustained or expenses Incurred during military service while on active duty; or as a result of enemy action or act of war, whether declared or undeclared.
- For which a Covered Person would have no legal obligation to pay;
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- For payment made under Medicare when Medicare is primary or would have been made if the Covered Person had enrolled for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the Fund is obligated by law to offer the Covered Person all the benefits of this program and the Covered Person so elects this coverage as primary;
- For any occupational 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 the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Covered Person claims the benefits or compensation;
- To the extent benefits are provided by the Veteran's Administration or by the Department of Defense for members of the armed forces of any nation while on active duty;
- For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
- For drugs or medicines for which the Covered Person has coverage under a free-standing prescription drug program provided through the Enrolled Fund;
- Which are not billed and performed by a Provider unless otherwise indicated under the subsections entitled "Therapy Services" and "Ambulance Services" in the "Your Personal Choice Benefits" section of this booklet/certificate;
- Rendered by a member of the Covered Person's Immediate Family;
- Performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program and are provided through a hospital or university;
- For ambulance services except as specifically provided under this coverage;
- For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected. However, benefits are

payable to correct a condition resulting from an accident. Benefits are also payable to correct functional impairment which results from a covered disease, injury or congenital birth defect. This exclusion does not apply to mastectomy related charges as provided for and defined in the subsection entitled SURGICAL SERVICES in the "Your Personal Choice Benefits" section of this booklet/certificate;

- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- For music therapy;
- For marriage counseling;
- For Custodial Care, domiciliary care or rest cures;
- For equipment costs related to services performed on high cost technological equipment as defined by the Carrier, such as, but not limited to, computer tomography (CT) scanners, magnetic resonance imagers (MRI) and linear accelerators, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or by the Carrier;
- 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, except as specifically stated under the coverage. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy, bone grafts or other procedures provided to augment an atrophic mandible or maxilla in preparation of the mouth for dentures or dental implants, and treatment of periodontal disease unless otherwise indicated. This exclusion does not apply to orthodontic treatment for congenital cleft palates, as provided for and defined in the subsection entitled SURGICAL SERVICES in the "Your Personal Choice Benefits" section of this booklet/certificate;
- For treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices or with any non-surgical method to alter vertical dimension;
- For palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone Surgery), calluses, toe nails (except Surgery for ingrown nails), fallen arches, pes planus (flat feet), weak feet, chronic foot strain, and symptomatic complaints of the feet;
- For supportive devices of the foot (orthotics), except for podiatric appliances for the prevention of complications associated with diabetes;
- For hearing aids or hearing examinations or tests 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 surgery;
- For assisted fertilization techniques such as, but not limited to, artificial insemination, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);
- For treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury;
- For treatment of obesity, except for surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex;
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness or exercise equipment, radio and television, beauty/barber shop services, guest trays, wigs, chairlifts, stairglides, elevators, spa or health club memberships, whirlpool, sauna, hot tub or equivalent device, whether or not recommended by a Provider;
- For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or

contact lenses unless otherwise indicated;

- For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
- For preventive services except as specifically provided for under the subsection entitled "Primary Services" of the "Your Personal Choice Benefits" section of this booklet/certificate;
- For weight reduction and premarital blood tests;
- For diagnostic screening examinations, except for mammograms and preventive care as provided in the subsection entitled "Primary Care Services" of "Your Personal Choice Benefits" section of this booklet/certificate;
- For acupuncture;
- For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider;
- For immunizations required for employment purposes, or for travel;
- For care in a nursing home, home for the aged, convalescent home, school, institution for retarded children, Custodial Care in a Skilled Nursing Facility;
- For counseling or consultation with a patient's relatives, or Hospital charges for a patient's relatives or guests, except as may be specifically provided in the subsection entitled "Treatment for Alcohol or Drug Abuse and Dependency" or except as may be allowed under the subsection entitled "Transplant Services" of "Your Personal Choice Benefits" section of this booklet/certificate;
- For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits, and home blood pressure machines, except for Covered Persons with pregnancy-induced hypertension;
- For prescription drugs;
- For amino acid supplements, appetite suppressants or nutritional supplements. Coverage does not include basic milk, soy, or casein hydrolyzed formulas (e.g., Nutramigen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy. This exclusion does not apply to Medical Foods and Nutritional Formulas as provided for and defined in the subsection entitled "Medical Foods and Nutritional Formulas" in the section entitled "Your Personal Choice Benefits";
- For Inpatient Private Duty Nursing services;
- For any care that extends beyond traditional medical management for autistic disease of childhood, Pervasive Development Disorders, Attention Deficit Disorder, learning disabilities, behavioral problems, or mental retardation; or treatment or care to effect environmental or social change;
- For charges incurred for expenses in excess of Benefit Maximums as specified in the Schedule of Benefits;
- For research studies;
- For treatment of substance abuse;
- For treatment of mental health;
- For maternity services for Dependent daughters, except for those services pertaining to complications of pregnancy;

- For Maintenance of chronic conditions, injuries or illness when response to treatment has reached the maximum therapeutic level, no additional functional improvement can be demonstrated or anticipated, and continuation of the service will be of no therapeutic value to the Covered Person;
- For Cognitive Rehabilitative Therapy; (Cognitive Rehabilitative Therapy is a therapeutic approach designed to improve cognitive functioning after central nervous system injury or trauma. It includes therapy methods that retrain or alleviate problems caused by deficits in attention, visual processing, language, memory, reasoning and problem solving. It utilizes tasks designed to reinforce or reestablish previously learned patterns of behavior or to establish new compensatory mechanisms for the impaired neurologic system);
- For any other service or treatment except as provided under the coverage.

GENERAL INFORMATION

BENEFITS TO WHICH YOU ARE ENTITLED

The liability of the Carrier is limited to the benefits specified in this booklet/certificate. The Carrier's determination of the benefit provisions applicable for the services rendered to you shall be conclusive.

TERMINATION OF YOUR COVERAGE AND CONVERSION PRIVILEGE UNDER THIS FUND COVERAGE

Termination of the Fund coverage - Termination of the Fund coverage automatically terminates all coverage for you and your eligible Dependents. The privilege of conversion to a conversion contract shall be available to any Covered Person who has been continuously covered under the fund contract for at least three months (or covered for similar benefits under any group plan that this fund plan replaced).

Termination of the Fund coverage automatically terminates all of your coverage and the coverage of your eligible Dependents. It is the responsibility of the Fund to notify you and your eligible Dependents of the termination of coverage. However, coverage will be terminated regardless of whether the notice is given.

If it is proven that you or your eligible Dependent obtained or attempted to obtain benefits or payment for benefits, through fraud or intentional misrepresentation, the Carrier, may, upon notice to you, terminate the coverage.

The privilege of conversion is available for you and your eligible Dependents except in the following circumstances:

- a. The Fund terminates this coverage in favor of group coverage by another organization; or
- b. The Fund terminates the Covered Person in anticipation of terminating this coverage in favor of group coverage by another organization.

It is the responsibility of the Fund or the Fund's Applicant Agent to notify you of the termination of the coverage.

Notice of Conversion - Written notice of termination and the privilege of conversion to a conversion contract shall be given within fifteen days before or after the date of termination of the fund coverage, provided that if such notice is given more than fifteen days but less than ninety days after the date of termination of fund coverage, the time allowed for the exercise of the privilege of conversion shall be extended for fifteen days after the giving of such notice. Payment for coverage under the conversion contract must be made within 31 days after the coverage under this Plan ends. Evidence of insurability is not required. Upon receipt of this payment, the conversion contract will be effective on the date of your termination under this fund Plan.

When a Covered Person ceases to be an Eligible Member or Eligible Dependent, or the required contribution is not paid, the Covered Person's coverage will terminate at the end of the last month for which payment was made. However, if benefits under this coverage are provided by and/or approved by the Carrier before the Carrier receives notice of the Covered Person's termination under the Fund Contract, the cost of such benefits will be the sole responsibility of the Covered Person. In that circumstance, the Carrier will consider the effective date of termination of a Covered Person under the Fund Contract to be not more than 60 days before the first day of the month in which the Fund notified the Carrier of such termination.

Conversion coverage shall not be available if you are eligible for another health care program which is available in the Fund where the Covered Person is employed or with which the Covered Person is affiliated to the extent that the conversion coverage would result in over-insurance.

If your coverage or the coverage of your eligible dependent terminates because of your death, your change in employment status, divorce of dependent spouse, or change in a dependent's eligibility status, the terminated Covered Person will be eligible to apply within 31 days of termination (or termination of the continuation privileges under COBRA) to conversion coverage, of the type for which that person is then qualified at the rate then in effect. This conversion coverage may be different from the coverage provided under this coverage. Evidence of insurability is not required.

CONTINUATION OF COVERAGE AT TERMINATION OF EMPLOYMENT OR MEMBERSHIP DUE TO TOTAL DISABILITY

Your protection under this coverage may be extended after the date you cease to be a Covered Person under the coverage because of termination of employment or termination of membership in the Fund. It will be extended if, on that date, you are totally disabled from an illness or injury. The extension is only for that illness or injury and any related illness or injury. It will be for the time you remain Totally Disabled from any such illness or injury, but not beyond twelve months if you cease to be a Covered Person because your coverage under the Fund Contract ends.

Coverage under this Plan will apply during an extension as if you were still a Covered Person, except any reinstatement of your Lifetime Maximum amount will not be allowed under the Reinstatement subsection as set forth in the Schedule of Benefits section of this booklet. In addition, coverage will apply only to the extent that other coverage for the Covered Services is not provided for you through the Carrier by the Group. Continuation of coverage is subject to payment of the applicable premium.

CONTINUATION OF INCAPACITATED CHILD

If an unmarried child is incapable of self-support because of mental or physical incapacity and is dependent on you for over half of his support, you may apply to the Carrier to continue coverage of such child under the Carrier upon such terms and conditions as the Carrier may determine. Coverage of such Dependent child shall terminate upon his or her marriage. Continuation of benefits under this provision will only apply if the child was eligible as a dependent and mental or physical incapacity commenced prior to age 19.

The child must be unmarried, incapable of self-support and the disability must have commenced prior to attaining 19 years of age. The disability must be certified by the attending physician; furthermore, the disability is subject to annual medical review. In a case where a handicapped child is over 19 years of age and joining the Carrier for the first time, the handicapped child must have been covered under the prior carrier and submit proof from the prior carrier that the child was covered as a handicapped person.

WHEN YOU TERMINATE EMPLOYMENT - CONTINUATION OF COVERAGE PROVISIONS - COBRA

For purposes of this subsection of your booklet/certificate, A "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this subsection, is covered for group health benefits under this Plan as:

- a. you, an active, covered Member;
- b. your spouse; or
- c. your Dependent child.

In addition, any child born to or placed for adoption with you during COBRA continuation will be a qualified continuee.

Any person who becomes covered under this Plan during COBRA continuation, other than a child born to or placed for adoption with you during COBRA continuation, will not be a qualified continuee.

If A Member Terminates Employment or Has a Reduction of Work Hours: If your group benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if:

- a. your termination of employment was not due to gross misconduct; and
- b. you are not entitled to Medicare.

The continuation will cover you and any other qualified continuee who loses coverage because of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, subject to the ‘When Continuation Ends’ paragraph of this subsection.

Extra Continuation for Disabled Qualified Continuees: If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the day before the qualified continuee's health benefits would otherwise end due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours or within 60 days of that date, the qualified continuee and any other affected qualified continuees may elect to extend the 18 month continuation period described above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Plan Administrator must be given written proof of Social Security’s determination of the qualified continuee’s disability before the earlier of:

- a. The end of the 18 month continuation period; and
- b. 60 days after the date the qualified continuee is determined to be disabled.

If, during the 11 month continuation period, the qualified continuee is determined to be no longer disabled under the United States Social Security Act, the qualified continuee must notify the Plan Administrator within 30 days of such determination, and continuation will end, as explained in the “When Continuation Ends’ paragraph of this subsection.

If a Member Dies: If you die, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the ‘When Continuation Ends’ paragraph of this subsection.

If a Member’s Marriage Ends: If your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the ‘When Continuation Ends’ paragraph of this subsection.

If a Member Becomes Entitled to Medicare: If you become entitled to Medicare **after** terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months from the date the initial 18 month continuation period started, subject to the ‘When Continuation Ends’ paragraph of this subsection.

If you become entitled to Medicare **before** terminating employment (for reasons other than gross misconduct) or experiencing a reduction of work hours and, during the subsequent 18-month period, you terminate employment (for reasons other than gross misconduct) or have a reduction of work hours, all qualified continuees other than you whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 18 months, but may be extended until 36 months from the date you became entitled to Medicare, subject to the ‘When Continuation Ends’ paragraph of this subsection.

If a Dependent Loses Eligibility: If your Dependent child’s group health benefits end due to his or her loss of dependent eligibility as defined in this booklet, other than your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to the ‘When Continued Ends’ paragraph of this subsection.

Concurrent Continuations: If your Dependent who is a qualified continuee elects to continue his or her group health benefits due to your termination of employment (for reasons other than gross misconduct) or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above.

The 36 month continuation period starts on the date the initial 18 month continuation period started, and the two continuation periods will run concurrently.

The Qualified Continuee's Responsibilities: A person eligible for continuation under this subsection must notify the Plan Administrator, in writing, of:

- a. your legal divorce or legal separation from your spouse; or
- b. your Dependent child's loss of dependent eligibility, as defined in this booklet.

The notice must be given to the Plan Administrator within 60 days of either of these events.

In addition, a disabled qualified continuee must notify the Plan Administrator, in writing, of any final determination that the qualified continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act. The notice must be given to the Plan Administrator within 30 days of such final determination.

The Employer's Responsibilities. Your Employer must notify the Plan Administrator, in writing, of:

- a. your termination of employment (for reasons other than gross misconduct) or reduction of work hours;
- b. your death; or
- c. your entitlement to Medicare.

The notice must be given to the Plan Administrator within 60 days of any of these events.

The Plan Administrator's Responsibilities: The Plan Administrator must notify the qualified continuee, in writing, of:

- a. his or her right to continue the group health benefits described in this booklet;
- b. the monthly premium he or she must pay to continue such benefits; and
- c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

- a. the date the Employer notifies the Plan Administrator, in writing, of your termination of employment (for reasons other than gross misconduct) or reduction of work hours, your death, or your entitlement to Medicare; or
- b. the date the qualified continuee notifies the Plan Administrator, in writing, of your legal divorce or legal separation from your spouse, or your Dependent child's loss of eligibility.

The Employer's Liability: Your Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in the place of, the Plan, if:

- a. the Employer fails to remit a qualified continuee's timely premium payment to the Plan on time, thereby causing the qualified continuee's group health benefit to end; or
- b. the Plan Administrator fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation: To continue his or her group health benefits, the qualified continuee must give the Plan Administrator written notice that he or she elects to continue benefits under the coverage. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Plan Administrator as described above or 60 days of the date the qualified continuee's group health benefits end, if later. Furthermore, the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Plan Administrator by the qualified continuee, in advance, at the time and in the manner set forth by the Plan Administrator. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under this benefit plan on a regular basis. It includes any amount that would have been paid by the Employer. An additional charge of two percent of the total premium charge may also be required by the Employer.

Qualified continuees who receive the extended coverage due to disability described above may be charged an additional 50% of the total premium charge during the extra 11 month continuation period.

If the qualified continuee fails to give the Plan Administrator notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment in Premiums: A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, the premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends: A qualified continuee's continued group health benefits under this coverage ends on the first to occur of the following:

- a. with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- b. with respect to a disabled qualified continuee and his or her family members who are qualified continuees who have elected an additional 11 months of continuation, the earlier of:
 - i. the end of the 29 month period which starts on the date the group health benefits would otherwise end;
 - or
 - ii. the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;
- c. with respect to continuation upon your death, your legal divorce or legal separation, or the end of your covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- d. with respect to your Dependent whose continuation is extended due to your entitlement to Medicare,
 - i. **after** your termination of employment or reduction of work hours, the end of the 36 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours; and
 - ii. **before**, your termination of employment or reduction of work hours where, during the 18-month period following Medicare entitlement, you terminate employment or have a reduction of work hours, at least to the end of the 18 month period beginning on the date coverage would otherwise end due to your termination of employment or reduction of work hours, but not less than 36 months from the date you become entitled to Medicare.
- e. the date this coverage ends;
- f. the end of the period for which the last premium payment is made;

- g. the date he or she becomes covered under any other group health plan (as a member or otherwise) which contains no limitation or exclusion with respect to any pre-existing condition of the qualified continuee other than a pre-existing condition exclusion or limitation which he or she satisfies under the Health Insurance Portability and Accountability Act of 1996, as first constituted or later amended;
- h. the date he or she becomes entitled to Medicare.

THE CARRIER'S RESPONSIBILITIES RELATIVE TO THE PROVISION OF CONTINUATION COVERAGE UNDER THIS COVERAGE ARE LIMITED TO THOSE SET FORTH IN THIS SUBSECTION OF YOUR BOOKLET/CERTIFICATE.

THE CARRIER IS NOT THE PLAN ADMINISTRATOR UNDER THE COVERAGE OR FOR PURPOSES OF ERISA OR ANY OTHER FEDERAL OR STATE LAW. IN THE ABSENCE OF THE DESIGNATION OF ANOTHER PARTY AS PLAN ADMINISTRATOR, THE PLAN ADMINISTRATOR SHALL BE THE EMPLOYER.

RELEASE OF INFORMATION

Each Covered Person agrees that any person or entity having information relating to an illness or injury for which benefits are claimed under this Plan may furnish to the Carrier, upon its request, any information (including copies of records relating to the illness or injury).

In addition, the Carrier may furnish similar information to other entities providing similar benefits at their request.

The Carrier shall provide to the Fund at the Fund's request certain information regarding claims and charges submitted to the Carrier. The parties understand that any information provided to the Fund will be adjusted by the Carrier to prevent the disclosure of any information that is protected by applicable state or federal laws of any member or other patient treated by said Providers. The Fund shall reimburse the Carrier for the actual costs of preparing and providing said information.

The Carrier may also furnish other plans or plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

When the Carrier needs to obtain consent for the release of personal health information, authorization of care and treatment, or to have access to information from a Covered Person who is unable to provide it, the Carrier will obtain consent from the parent, legal guardian, next of kin, or other individual with appropriate legal authority to make decisions on behalf of the Covered Person.

CONSUMER RIGHTS

Each Covered Person has the right to access, review and copy their own health and membership records and request amendments to their records. This includes information pertaining to claim payments, payment methodology, reduction or denial, medical information secured from other agents, plans or providers.

For more information about accessing, reviewing or copying records, call Member Services at the toll-free number on your ID card.

LIMITATION OF ACTIONS

No legal action may be taken to recover benefits prior to 60 days after notice of claim has been given as specified above, and no such action may be taken later than two years after the date Covered Services are rendered.

CLAIM FORMS

The Carrier will furnish to you or to the Fund Contractholder, for delivery to you, such claim forms as are required for filing proof of loss for Covered Services provided by Non-Preferred Providers.

TIMELY FILING

The Carrier will not be liable under the coverage unless proper notice is furnished to the Carrier that Covered Services have been rendered to a Covered Person. Written notice must be given within 20 days after completion of the Covered Services. The notice must include the date and information required by the Carrier to determine benefits. An expense will be considered Incurred on the date the service or supply was rendered.

Failure to give notice to the Carrier within the time specified will not reduce any benefit if it is shown that the notice was given as soon as reasonably possible, but in no event will the Carrier be required to accept notice more than two years after the end of the Benefit Period in which the Covered Services are rendered.

The above is not applicable to claims administered by Preferred Providers.

MEMBER/PROVIDER RELATIONSHIP

- a. The choice of a Provider is solely yours.
- b. The Carrier does not furnish Covered Services but only makes payment for Covered Services received by persons covered under the Carrier. The Carrier is not liable for any act or omission of any Provider. The Carrier has no responsibility for a Provider's failure or refusal to render Covered Services to a Covered Person.

SUBROGATION

In the event any service is provided or any payment is made to you or your covered Dependent under this Plan, the Carrier shall be subrogated and succeed to your rights of recovery against any person, firm, corporation, or organization except against insurers on policies of insurance issued to and in your name. You shall execute and deliver such instruments and take such other reasonable action as the Carrier may require to secure such rights. You may do nothing to prejudice the rights given the Carrier without the Carrier's consent.

You shall pay the Carrier all amounts recovered by suit, settlement, or otherwise from any third party or his insurer to the extent of the benefits provided or paid under this Carrier and as permitted by law.

The Carrier's right of subrogation shall be unenforceable when prohibited by law.

COORDINATION OF BENEFITS

This Plan's Coordination of Benefits provision is designed to conserve funds associated with health care. The following provisions do not apply to prescription drug coverage when provided through endorsement to the Fund Contract.

1. **Definitions**

In addition to the Definitions of this Plan for purposes of is Provision only:

"Plan" shall mean any group arrangement providing health care benefits or Covered Services through:

- a) individual, group, (except hospital indemnity plans of less than \$100), blanket (except student accident) or franchise insurance coverage;
- b) the Plan, health maintenance organization and other prepayment coverage;
- c) coverage under labor management trusted plans, union welfare plans, Employer organization plans, or Member benefit organization plans; and
- d) coverage under any tax supported or government program to the extent permitted by law.

2. **Determination of Benefits**

Coordination of Benefits (COB) applies when a Member has health care coverage under any other group health care plan (Plan) for services covered under this Plan, or when the Member has coverage under any tax-supported or governmental program unless such program's benefits are, to the extent permitted by law, excess to those of any private insurance coverage. When COB applies, payments may be coordinated between QCC and the other Plan in order to avoid duplication of benefits.

Benefits under this Plan will be provided in full when QCC are primary, that is, when QCC determine benefits first. If another Plan is primary, QCC will provide benefits as described below.

When a Member has group health care coverage under this Plan and another Plan, the following will apply to determine which coverage is primary:

- a) If the other Plan does not include rules for coordinating benefits, such other Plan will be primary.
- b) If the other Plan includes rules for coordinating benefits:
 - 1) The Plan covering the patient other than as a Dependent shall be primary.
 - 2) The Plan covering the patient as a Dependent of the parent whose date of birth, excluding year of birth, occurs earlier in the calendar year shall be primary, unless the child's parents are separated or divorced and there is no joint custody agreement. If both parents have the same birthday, the Plan which covered the parent longer shall be primary. However, if the other Plan does not have the birthday rule as described herein, but instead has a rule based on the gender of the parent, and if as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall control unless the child's parents are separated or divorced.
 - 3) Except as provided in subparagraph (4) below, if the child's parents are separated or divorced and there is no joint custody agreement, benefits for the child are determined as follows:
 - i) First, the Plan covering the child as a Dependent of the parent with custody;
 - ii) then, the Plan of the spouse of the parent with custody of the child;
 - iii) finally, the Plan of the parent not having custody of the child.

- 4) When there is a court decree which establishes financial responsibility for the health care expenses of the Dependent child and the Plan covering the parent with such financial responsibility has actual knowledge of the court decree, benefits of that Plan are determined first.
- 5) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above in 2 (b) (2).
- c) The Plan covering the patient as a Member who is neither laid off nor retired (or as that Member's Dependent) is primary to a Plan which covers that patient as a laid off or retired member (or as that Member's Dependent). However, if the other Plan does not have the rule described immediately above and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
- d) If none of the above rules apply, the Plan which covered the Member longer shall be primary.

3. **Effect on Benefits**

When the QCC Plan is secondary, the benefits under this Plan will be reduced so that QCC will pay no more than the difference, if any, between the benefits provided under the other Plan for services covered under this Plan and the total Covered Services provided to the Member. Benefits payable under another Plan include benefits that would have been payable had the claim been duly made therefor. In no event will a QCC payment exceed the amount that would have been payable under this Plan if QCC were primary.

When the benefits are reduced under the Primary plan because a Member does not comply with the Plan provision, or does not maximize benefits available under the Primary Plan, the amount of such reduction will not be considered an allowable benefit. Examples of such provisions are those related to second surgical opinion penalties, and penalties and increased coinsurance related to precertification of admissions and services, Preferred Provider arrangements and other cost-sharing features.

Certain facts are needed to apply COB. QCC has the right to decide which facts are needed. QCC may, without consent of or notice to any person, release to or obtain from any other organization or person any information, with respect to any person, which QCC deems necessary for such purposes. Any person claiming benefits under this Plan shall furnish to QCC such information as may be necessary to implement this provision. QCC, however, shall not be required to determine the existence of any other Plan or the amount of benefits payable under any such Plan, and the payment of benefits under this Plan shall be affected by the benefits that would be payable under any and all other Plans only to the extent that QCC is furnished with information relative to such other Plans.

Right of Recovery

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan, QCC shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits provided under this Plan and, to the extent of such payments, QCC shall be fully discharged from liability under this Plan.

Whenever payments have been made by QCC in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, QCC shall have the right to recover such payments to the extent of such excess from among one or more of the following, as QCC shall determine:

1. the person QCC has paid or for whom they have paid;
2. insurance companies; or
3. any other organizations.

You, on your own behalf and on behalf of your Dependents, shall, upon request, execute and deliver such instruments and papers as may be required and do whatever else is reasonably necessary to secure such rights to QCC.

MANAGED CARE

A. INPATIENT PRE-ADMISSION REVIEW

1. PREFERRED INPATIENT ADMISSIONS

All Preferred Inpatient Admissions must meet the requirements of the Carrier's designated agent for utilization management ("designated agent"). Under the program as described below, any Inpatient admission, other than an emergency or maternity admission, must be pre-certified in accordance with the standards of the Carrier as to the Medical Appropriateness of the admission. The precertification requirements for emergency admissions are set forth in Section MC-B. Preferred Hospitals, Skilled Nursing Facilities or other Facility Provider in the Personal Choice Network will verify the precertification at or before the time of admission. However, the Covered Person, not the Hospital, Skilled Nursing Facility or other Facility Provider, is responsible to pre-certify an Inpatient admission under the BlueCard PPO Program. The designated agent will not authorize the Hospital, Skilled Nursing Facility or other Facility Provider admission if precertification is required and is not obtained in advance. The Carrier will hold the Covered Person harmless and the Covered Person will not be financially responsible for admissions to Hospitals, Skilled Nursing Facilities or other Facility Provider in the Personal Choice Network which fail to conform to the pre-admission certification requirements unless: (1) the Hospital, the Skilled Nursing Facility or other Facility Provider provides prior written notice that the admission will not be paid by the Carrier; and (2) the Covered Person acknowledges this fact in writing together with a request to be admitted which states that he will assume financial liability for such Hospital, Skilled Nursing Facility or other Facility Provider admission.

2. NON-PREFERRED INPATIENT ADMISSIONS

For a Non-Preferred Inpatient Admission and an Inpatient Admission to a BlueCard PPO Provider, the Covered Person is responsible to have the admission (other than for a maternity admission) certified in advance as an approved admission.

- a. To obtain pre-admission certification, the Covered Person is responsible to contact or have the admitting Physician or Hospital, Skilled Nursing Facility or other Facility Provider contact the Carrier prior to admission to the Hospital, Skilled Nursing Facility or other Facility Provider. The Carrier will notify the Covered Person, admitting Physician and Hospital, Skilled Nursing Facility or other Facility Provider of the determination. The Covered Person is eligible for Inpatient benefits at the Non-Preferred level shown in the Schedule of Benefits if, and only if, prior approval of such benefits has been certified in accordance with the Fund Contract.
- b. If such prior approval for a Medically Appropriate Inpatient Admission has not been certified as required under the Fund Contract, there will be a penalty for non-compliance and the following amount will be deemed not to be Covered Services under the Fund Contract: \$1,000 of allowable charges. Such penalty, and any difference in what is covered by the Carrier and the Covered Person's obligation to the Provider will be the sole responsibility of, and payable by, the Covered Person.

If a Covered Person elects to be admitted to the Hospital, the Skilled Nursing Facility or other Facility Provider after review and notification that the reason for admission is not approved for a Inpatient level of care, Inpatient benefits will not be provided and the Covered Person will be financially liable for non-covered Inpatient charges.

- c. If pre-admission certification is denied, the Covered Person, the Physician, the Hospital, the Skilled Nursing Facility or other Facility Provider may appeal the determination and submit information in support of the claim for Inpatient benefits. A final determination concerning eligibility for Inpatient benefits will be made and the Covered Person, Physician, Hospital, Skilled Nursing Facility or other Facility Provider will be so notified.

B. EMERGENCY ADMISSION REVIEW

1. Covered Persons are responsible for notifying the designated agent of a Non-Preferred emergency admission for themselves or a Dependent within two (2) business days of the admission, or as soon as reasonably possible, as determined by the Carrier.
2. Failure to initiate emergency admission review will result in a reduction in Inpatient benefits of \$1,000 in Covered Expense for Non-Preferred services. Such penalty will be the sole responsibility of, and payable by, the Covered Person.
3. If the Covered Person elects to remain hospitalized after the designated agent and the attending physician have determined that an Inpatient level of care is not Medically Appropriate, the Covered Person will be financially liable for non-covered Inpatient charges from the date of notification.

C. CONCURRENT REVIEW

The designated agent assigns an estimated length of stay for all approved Inpatient Hospital admissions. It also approves admissions to Skilled Nursing Facilities and other types of care provided by other Facility Providers and Professional Providers as provided for in this Section MC. Concurrent review of an approved admission or plan of treatment may result in an approval of a request for an extension of approved care. The designated agent will verbally inform the Provider of the approval of any additional care as a result of the concurrent review. It will also continue to monitor extensions of care to determine when further Covered Services are no longer Medically Necessary/Medically Appropriate. The written determination by both the designated agent and the attending physician that Covered Services are no longer Medically Necessary/Medically Appropriate will result in the termination of benefits payable for the treatment of the illness or injury.

D. INDIVIDUAL CASE MANAGEMENT

Any Covered Person who suffers from a catastrophic illness or injury may be eligible for Individual Case Management (ICM). ICM focuses on the reduction of Inpatient Hospital utilization and is designed to address the needs of selected high-risk patients by coordinating the delivery of quality and cost-effective treatment modalities commensurate with the patient's needs. ICM involves individual benefits management for complex long-term medical needs.

The Carrier will identify cases where ICM may be appropriate for a Covered Person who suffers from a catastrophic illness or injury. Then the Carrier will assess the Covered Person's anticipated medical needs, after consultation with the attending Physician, the Covered Person and his/her family, where necessary. However, ICM will be made available to the Covered Person if, and only if, all of the following criteria are met:

- The Carrier determines that, without ICM, the Covered Person will have to remain in a more costly setting to receive the appropriate quality or intensity of care;
- The attending Physician determines that a different course of treatment or services is responsive to the needs of the Covered Person; and
- The plan of treatment will be implemented only with the concurrence of the Carrier, the contractholder, the attending Physician, the Covered Person and his/her family, where applicable.

Following implementation, ICM will continue until:

- The patient's medical goals (as identified in the approved Plan of Treatment) are met and additional services are not Medically Necessary/Medically Appropriate, as determined by the Carrier;
- In the opinion of the attending Physician, the patient's condition no longer requires the services provided under the approved Plan of Treatment, and a different course of treatment is appropriate;
- The patient exhausts benefits provided under the Fund Contract or under the approved Plan of

Treatment; or

- The contractholder, the patient (or the patient's family, where necessary) or the Carrier terminates ICM upon appropriate notice.

E. COMPREHENSIVE DISEASE MANAGEMENT PROGRAM

Comprehensive Disease Management programs include preventive intervention programs that have been developed to serve individuals who have been diagnosed with a catastrophic or chronic illness. The objectives of Disease Management programs are to facilitate access by the patient to ensure the efficient use of resources, link patients with preventive health care services, assist providers in coordinating prescribed services, monitor the quality of delivered services and improve patient health outcomes. This Disease Management program is a system of locating, coordinating and evaluating a comprehensive, focused group of services for a Covered Person who has been diagnosed with a specific chronic illness. The Disease Management program utilizes a number of diagnosis-specific protocols for managing complex conditions. Interventions are intended not only to improve the delivery of health care services for subscribers in active stages of the disease process, but also to help prevent acute exacerbations of the disease or condition by coordinating appropriate health care services.

Participation in the Disease Management program is voluntary. Covered Persons agree to participate in the program as well as authorize the Carrier to utilize a patient's medical information for program purposes. Case managers shall be specially assigned to coordinate services under the program. Upon approval by the Carrier, a Covered Person may participate in the Disease Management program where: (1) he/she has been diagnosed and/or suffers from a specific chronic illness; (2) the Covered Person agrees to participate in the program; and (3) the objectives of the program for the subject illness can be met. A Plan of Treatment for a Covered Person in the Disease Management program will typically include an assessment of a Covered Person's long-range medical needs, the provision of preventive services counseling/education and other treatment modifications that will delay or prevent the progression of the condition. Benefits for services not otherwise covered under the Covered Person's contract may be approved as a part of participant's Plan of Treatment where the objectives of the Disease Management program are achieved.

A Covered Person may continue in the Disease Management program until any of the following occurs: (1) the Covered Person decides to end participation in the program; (2) the Carrier determines that the program objectives can no longer be achieved; or (3) the Covered Person exhausts benefits provided under his/her contract or under the approved Plan of Treatment.

F. PRECERTIFICATION REQUIREMENTS FOR OTHER THAN INPATIENT ADMISSIONS

Precertification is required by the Carrier in advance of an admission in a Skilled Nursing Facility or Birth Center. Precertification is also required in advance for Home Health Care, Hospice Care, certain Surgical, Diagnostic, Preferred Outpatient Serious Mental Illness treatment and/or Serious Mental Illness Partial Hospitalization services, Restorative and Outpatient Therapy services which are identified below, non-emergency Ambulance services, Outpatient transplants and Durable Medical Equipment and Prosthetics exceeding the purchase price of \$100. When a Covered Person plans to receive any of these procedures, the Carrier must review the Medical Necessity/Medical Appropriateness for the procedure and grant prior approval of benefits.

Surgery, diagnostic and other listed procedures performed during an emergency, as determined by the Carrier, do not require precertification. However, the Carrier should be notified within two (2) business days of emergency services for those procedures listed herein, or as soon as reasonably possible, as determined by the Carrier.

1. Preferred Care

Preferred Providers in the Personal Choice Network must contact the Carrier to initiate precertification. The Carrier will verify the results of the precertification with the Covered Person and with the Preferred Provider. If the Preferred Provider is a BlueCard PPO Provider, however, the Covered Person must initiate precertification.

If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other listed procedure, then benefits will be provided for Medically Necessary/Medically Appropriate Procedures, subject to a penalty.

For Preferred Providers in the Personal Choice Network, the Carrier will hold the Covered Person harmless and the Covered Person will not be financially responsible for this financial penalty for the Preferred Provider's failure to comply with the precertification requirements or determination, unless a Covered Person elects to receive the elective surgical, diagnostic or other listed procedure after review and written notification that the procedure is not covered as Medically Necessary/Medically Appropriate. In which case benefits will not be provided and the Covered Person will be financially liable for non-covered charges.

2. Non-Preferred Care

For Non-Preferred Care the Covered Person is responsible to ~~contact~~ or have the Provider performing the service contact the Carrier to initiate precertification. The Carrier will verify the results of the precertification with the Covered Person and the Provider.

If such prior approval is not obtained and the Covered Person undergoes the surgical, diagnostic or other listed procedure, then benefits will be provided for Medically Necessary/Medically Appropriate Procedures, but the Provider's charge less any applicable Coinsurance, Co-payments, Deductibles or penalties shall be subject to a penalty of 20% for Professional Provider Services. Such penalty, and any difference in what is covered by the Carrier and the Covered Person's obligation to the Provider, will be the sole responsibility of, and payable by, the Covered Person.

3. Services Requiring Precertification

a. Outpatient Surgical Procedures - Preferred and Non-Preferred

- Bunionectomy
- Laparoscopic Cholecystectomy
- Hemorrhoidectomy
- Arthroscopic Knee Surgery and Diagnostic Arthroscopy
- Ligation and Stripping of Varicose Veins
- Submucous Resection (Nasal Surgery)
- Tonsillectomy and/or Adenoidectomy

b. Non-Preferred Surgical and Diagnostic Procedures

- Cataract Surgery
- Hernia Repair
- Prostate Surgery
- Spinal and Vertebral Surgery
- Operative and Diagnostic Endoscopies
- MRI
- CAT Scan

All Preferred and Non-Preferred services listed below must be pre-certified

c. Therapy Services:

Physical Therapy
Speech Therapy
Occupational Therapy
Cardiac Rehabilitation Therapy
Respiratory Therapy
Pulmonary Rehabilitation Therapy
Infusion Therapy

d. Restorative Services

e. Outpatient Private Duty Nursing Services

f. Other Facility Services

Skilled Nursing Facility
Home Health Care
Hospice Care
Birth Center

g. Other Services and Supplies:

Durable Medical Equipment
Prosthetics
Non-emergency Ambulance Services
Transplants

The Carrier reserves the right to modify the above list of procedures and services that require precertification after written notice has been given to the Fund.

G. Out-of-Area Care for Dependent Students

If an unmarried Dependent child is a full-time student in an Accredited Educational Institution located outside the area served by the Personal Choice Network, the student may be eligible to receive Non-Preferred care at the Preferred level of benefits. Charges for treatment will be paid at the Preferred level of benefits when the Dependent student receives care from Providers as described in the subsection entitled "BlueCard PPO Program" of the General Information section of this booklet/certificate. However, treatment provided by an educational facility's infirmary for sick/urgent care, for example, may also be paid at the Preferred level of benefits, but the Carrier should be notified within 48 hours of treatment to insure covered services are treated as Preferred Services. Nothing in this provision will act to continue coverage of a Dependent child past the date when such child's coverage would otherwise be terminated under the Fund Contract.

RESOLVING PROBLEMS

For purposes of this section only, the term “Member” replaces the term “Covered Person”.

Member Complaint Process

Carrier has a process for Members to express complaints. To register a complaint, Members should call the Member Services Department at the telephone number on the back of your identification card or write to the Carrier at the following address:

General Correspondence
1901 Market Street
Philadelphia, PA 19103

Most Member concerns are resolved informally at this level. However, if Carrier is unable to immediately resolve your complaint, it will be investigated and you will receive a response in writing within thirty (30) days.

Member Appeal Process

Carrier maintains procedures for the resolution of Member appeals. Member Appeals may be filed within 60 days of the receipt of the decision from the Plan. An appeal occurs when the Member or, after obtaining the Member’s consent, either the provider or another authorized representative requests a change of a previous decision made by the Carrier. The Member or other authorized person on behalf of the Member, may request an appeal by calling or writing to the Carrier, as defined in the letter notifying the Member of the decision. Following are the two types of Member appeals and the issues they address:

Medical Necessity Appeal Issues – An appeal by or on behalf of a Member that focuses on issues of Medical Necessity or Medical Appropriateness and requests the Carrier to change its decision to deny or limit the provision of a Covered Service.

Administrative Appeal Issues – An appeal by or on behalf of a Member that focuses on unresolved Member disputes or objections regarding a Carrier decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Necessity and Medical Appropriateness, these are not the primary issues that affect the outcome of the appeal.

The Member or the other authorized person appealing on the Member’s behalf may request an expedited appeal – a faster review, according to the procedures described below – on a Medical Necessity appeal issue. The Carrier will conduct an expedited appeal on a Medical Necessity appeal issue when it determines that delay in decision-making would seriously jeopardize the member’s life, health or ability to regain maximum function.

I Level One Appeal (First Level)

An acknowledgement letter and description of the appeal process is mailed within five (5) business days of receipt of a Member appeal. The initial request for an appeal will be evaluated within thirty (30) days of receipt of an appeal in the case of a standard appeal on an administrative issue or Medical Necessity appeal issue.

If an expedited appeal is conducted for a Medical Necessity appeal issue, you will receive a response that states the decision on the first level appeal no later than 48 hours after Carrier received the expedited appeal request, with a written decision notice sent within 2 business days of the decision.

For any standard appeal, you will be notified in writing of the first level decision within five (5) business days after the decision on the Medical Necessity/Appropriateness or administrative appeal issue. The first level appeal decision on a standard or expedited appeal is final unless you exercise your right to appeal the decision as described below.

II Level Two Appeal (Second Level)

If you are not satisfied with the first level decision, you may request a second level appeal within sixty (60) days. The appeal will be reviewed within forty-five (45) days of receipt of a standard appeal, or within 48 hours for an expedited appeal. Written notice of the second level decision will be sent within five (5) business days for standard appeals, or within 2 business days of the decision for expedited appeals. The second level decision is final with respect to a Covered Person's right to appeal through the Carrier's internal appeal process.

The policy and procedures for Member appeals may change due to changes that the Carrier makes to comply with applicable state and federal laws and regulations, to satisfy standards of certain recognized accrediting agencies, or to otherwise improve the Member Appeals process.

