SUMMARY PLAN DESCRIPTION

UWF

United Welfare Fund – Welfare Division

November 2023

Summary Plan Description

For

United Welfare Fund
Welfare Division

145 Huguenot Street - Suite 100
New Rochelle, NY 10801

Effective Date: April 1, 2018

Amended through November 1, 2023

PLAN ADMINISTRATOR:
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CLAIMS ADMINISTRATORS:
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SECTION 1: CONTACT INFORMATION

You should be able to contact the plan how, when and where you want to. The Plan's website www.uswu.org/benefits is available 24 hours a day, seven days a week to obtain answers to your questions.

If you need to reach the Plan by mail or telephone, it's important for you to know how. The following is a list intended to make your interactions with the Plan a little bit easier!

MEMBER SERVICES

1-718-658-4848

United Welfare Fund
c/o Leading Edge Administrators
Customer Service Representatives are available
Monday- Friday 8:00 a.m. to 6:00 p.m. 1-877-797-2776
Email: UWFmemberservices@leadingedgeadmin.com
Website URL to view claims: uwf-portal@leadingedgeadmin.com

PROVIDER NETWORK

1-800-810-2583

Anthem Blue Cross Blue Shield
c/o Leading Edge Administrators
Website URL: www.anthem.com
Live Health Online: www.livehealthonline.com 1-888-548-3432

Provider to submit claims to the Blue Cross Blue Shield Plan in the state where services are rendered

PRESCRIPTION BENEFITS

1-877-647-4026

Magellan Rx Management
c/o Leading Edge Administrators
Website URL: www.mrxinfo.com
Submit Rx Claims to: 2520 Industrial Row Drive, Troy MI 48084

CLAIMS REVIEW AND APPEALS

1-877-797-2776

United Welfare Fund
c/o Leading Edge Administrators
Attention: Appeals Department
14 Wall Street, Suite 5B
New York, NY 10005

SECTION 2: INTRODUCTION

The Board of Trustees of the United Welfare Fund is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the United Welfare Fund Welfare Benefit Plans (Plan). It includes summaries of:

- who is eligible;
- services that are covered, called Covered Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

United Welfare Fund intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice (unless otherwise required by law). This SPD is not to be construed as a contract of or for employment. This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

Leading Edge Administrators (LEA) is a private healthcare claims administrator and assists the Plan in claims administration. Although LEA can assist you in many ways, LEA does not guarantee any Benefits. The Board of Trustees for the United Welfare Fund, the Plan Administrator, is solely responsible for paying Benefits described in this SPD.

Full and final authority to interpret the terms of this Plan, adjudicate claims and make determinations as to their eligibility for payment by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, ERISA and other applicable laws. To receive due consideration, claims for Benefits and questions regarding said claims should be directed to LEA. The Plan Administrator may delegate to LEA responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). LEA is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Please read this SPD thoroughly to understand how the Plan works. If you have questions, you may contact the Plan Administrator or call the number on the back of your ID card.

HOW TO USE THIS SPD

- Read the entire SPD and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can obtain copies of your SPD and any amendments by contacting your Plan Administrator.
- Capitalized words in the SPD have special meanings and are defined by Sections or in the Glossary.
- If eligible for coverage, the words "you" and "your" refers to Participants as defined in the Glossary.
- The Board of Trustees of the United Welfare Fund is also referred to as Plan Sponsor or Plan Administrator.
- This SPD is the governing Plan Document for The United Welfare Fund Self-insured ERISA plan.
- You may obtain a copy of this Summary Plan Description (SPD) in the office of the Plan Administrator or at www.uswu.org/benefits

WHO CAN JOIN?

You are an eligible employee to enroll in the Plan if you are covered by a collective bargaining agreement or other agreement with the Union that provides that such employee is eligible to receive benefits, certain employees of the Union and the Plan who are likewise eligible to receive benefits, and certain Associate Members of the Union.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is:

- your Spouse;
- you or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian;
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both

covered under the Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in the Section titled, *Other Important Information*.

HOW TO ENROLL

To enroll, notify your Plan Administrator within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment Period to make your Benefit elections, unless you experience a change in status of HIPAA special enrollment known as a Qualifying Event.

Each year during annual Open Enrollment Period, you can review and change your medical election. Any changes you make during Open Enrollment will become effective the following plan year.

Important

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact your Plan Administrator within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment Period to change your elections.

WHEN COVERAGE BEGINS

Each Benefit provided by the plan has its own coverage commencement date. Certain benefits may require that you annually elect to enroll for that benefit. The Plan Administrator may require you to submit an election form and will inform you of the procedures for submitting election forms. Once you are enrolled in the Plan and contributions have been received on your behalf, you are a Plan "Participant". If you fail to enroll in the Plan during your first month after you are eligible, you are a "Late Enrollee". Your eligibility may depend on specific terms of the collective bargaining agreement covering your employment.

REINSTATEMENT OF COVERAGE

An employee who is terminated and rehired will be treated as an employee upon rehire only if the employee was not credited with an hour of service, as defined under the ACA, with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire. Upon return, coverage will be effective on the first of the month following the date of rehire, so long as all other eligibility criteria are satisfied.

CHANGING YOUR COVERAGE

You may make coverage changes during the year only if you experience a Qualifying Event. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered Qualifying Events:

- your marriage, divorce, legal separation or annulment;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who was enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage because of loss of eligibility (you must contact your Plan Administrator within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Plan Administrator within 60 days of determination of subsidy eligibility);

- a strike or lockout involving you or your spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact the Plan Administrator within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment Period.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example
Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in United Welfare Fund 's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under United Welfare Fund's medical plan outside of annual Open Enrollment.

SECTION 3: ELIGIBILITY

ELIGIBLE EMPLOYEE

You are an employee eligible to enroll in the Plan if you are covered by a collective bargaining agreement or other agreement with the Union that provides that such employee is eligible to receive benefits, certain employees of the Union and the Plan who are likewise eligible to receive benefits, and certain Associate Members of the Union.

ELIGIBLE DEPENDENT

The following are the guidelines to determine an eligible Dependent:

1. Unless otherwise set forth in this Section, coverage for an eligible Dependent who ceases to meet the definition of an eligible Dependent due to age automatically terminates and all benefits hereunder cease, at the end of the month in which the eligible Dependent ceases to be eligible.
2. A newborn child of the Participant will be covered for the first 48 hours after a vaginal delivery or for the first 96 hours after a cesarean delivery (coverage is limited to routine nursery care under the mother's benefit). Thereafter, the newborn will be covered only if the Participant enrolls the newborn child within 31 days of the birth and provides Plan Administrator with sufficient evidence to substantiate the eligibility of the newborn with official documents (such as a birth certificate) and pays any required premium. Then, coverage for the newborn child will be applied retroactively to the date of birth.
3. Grandchildren are not covered. Any services for a newborn child born to an Eligible Dependent are not covered under the Plan.
4. An Employee or Dependent may also be eligible for coverage under the Plan if they are entitled to enroll for coverage under this benefit program pursuant to the special enrollment rights granted under the Health Insurance Portability and Accountability Act of 1996.

EFFECTIVE DATE

The Effective Date for when coverage begins for an Eligible Employee or any other Covered Person, as applicable, is the date specified by the Employer in writing and received by the Plan Administrator, unless an earlier Effective Date is required by law.

ENROLLMENT

Once you become eligible you must enroll in the Plan if you want to receive benefits. You must enroll in the Plan within thirty-one (31) days of when you first become eligible. Obtain an Enrollment Form from the Plan Administrator and return the completed form immediately. If you do not, the start of your coverage will be delayed, and you will not have an opportunity to enroll until the Plan's next annual open enrollment period, unless you experience a change in status that is defined as a HIPAA special enrollment event.

For Dependent coverage, you must list your eligible Dependents with their dates of birth and submit legal marriage, birth, or adoption certificates.

The Plan will deny claims for benefits Incurred before your Enrollment Form was received by the Plan Administrator, or for a Dependent not listed on the form.

It is your obligation to keep the Plan Administrator informed and to file a new enrollment form within 31 days of any changes in:

- Address
- Dependent Status (Birth/Adoption of a child)
- Marital Status

The eligible Employee is responsible for providing the Plan Administrator with accurate and current enrollment information.

REQUESTS FOR INFORMATION

You are required to submit all documentation necessary to substantiate your eligibility or the eligibility of your Dependents whenever requested by the Plan Administrator. If you refuse or fail to furnish such documentation the Plan Administrator may deny eligibility or withdraw you and/or your Dependents from enrollment.

LATE ENROLLMENT

If you and/or your eligible Dependents did not enroll during your eligibility period or any special enrollment periods described in this Section, you will not be eligible for coverage until the next annual open enrollment period.

SPECIAL ENROLLMENT

This Plan provides special enrollment periods that allow you to enroll in the Plan, even if you declined enrollment during an initial or subsequent eligibility period.

If you declined enrollment for yourself or your dependents (including your spouse) because you had other health coverage, you may enroll for coverage for yourself and/or your dependents if the other health coverage is lost. You must complete a written application for special enrollment within thirty-one (31) days of the date the other health coverage was lost. For example, if you lose your other health coverage on September 15, you must notify the Plan Administrator and apply for coverage by close of business on October 16.

If you are an eligible Employee or Dependent and you lose your Medicaid or state Children's Health Insurance Program coverage, also called CHIP, you have sixty (60) days to elect coverage under the Plan. You or your eligible Dependents may enroll during this special enrollment period if the person who wishes to enroll, called the "enrollee," meets all of the following conditions:

- The enrollee is eligible for coverage under the terms of this Plan;
- The enrollee is not currently enrolled under the Plan;
- When enrollment was previously offered, the enrollee declined because of coverage under another group health plan or health insurance coverage. You or the enrollee must have provided a written statement and proof that other health coverage was the reason for declining enrollment under this Plan, if required by the Plan Administrator;
- The other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated. The enrollee is not eligible for this special enrollment right if:
- The other coverage was COBRA continuation coverage and the enrollee did not exhaust the maximum time available to you for that COBRA coverage; or
- The other coverage was lost due to non-payment of premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for the enrollee will be effective as of the first of the month following the date of the event, assuming that information is provided in the allowable timeframe.

SPECIAL ENROLLMENT FOR NEW DEPENDENTS

If you acquire a new dependent because of marriage, legal guardianship, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents during a special enrollment period. You must make written application for special enrollment no later than 31 days after you acquire the new Dependent, excluding the day of the acquisition. For example, if you are married on September 15, you must notify the Plan Administrator and apply for coverage by close of business on October 16.

You may enroll yourself and/or your eligible dependents during this special enrollment period if:

- You are eligible for coverage under the terms of this Plan, and
- You have acquired a new dependent through marriage, legal guardianship, birth, adoption or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for you and your dependent(s) will be effective at 12:01 a.m.:

- For a marriage, coverage will be effective as of the date of the marriage, assuming that information is provided in the allowable timeframe.
- For a legal guardianship, on the date on which such Child Dependent is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child Dependent.
- For a birth, within thirty-one (days) from the date of birth once receipt of proof of birth is received by the Plan.
- For an adoption or placement for adoption, on the date of the adoption or placement for adoption once receipt of proof of adoption is received by the Plan.

SECTION 4: HOW THE PLAN WORKS

GETTING STARTED

This document contains a detailed description of your Plan. You should be familiar with all of the Plan's terms and conditions. They determine what coverage you have and what amounts the Plan will pay. Whenever you need Covered Services, the Plan gives you a choice.

This Plan provides access to Covered Services from Providers within the Anthem Blue Cross Blue Shield (Anthem BCBS) Network. Under the Plan, you can receive Covered Services from the Anthem BCBS Network Providers Your out of pocket responsibility differs depending upon whether Covered Services are obtained through your Network or Out-of-Network Benefits. Generally, you will be responsible for paying a higher portion of your medical expenses when you are on a PPO plan and obtain Out-of-Network Benefits, but if you are on an EPO plan you will be responsible for all amounts charged by your Out-of-Network provider (except for emergency services which are addressed below). Please refer to your plan's Benefits Summary in the Appendix for specific out of pocket expenses. Your share of the costs will depend on the following:

ANNUAL DEDUCTIBLE

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Out-of-Network Covered Services before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Out-of-Network Deductible accumulate over the course of the calendar year.

COPAYMENT

A Copayment (Copay) is the amount you pay each time you receive certain Covered Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of- Pocket Maximum. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

COINSURANCE

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying for Out-of-Network Covered Services. Coinsurance is a fixed percentage that applies to certain Covered Services after you meet the Annual Deductible.

Coinsurance – Example

Let's assume that you receive Plan Benefits for outpatient surgery from an Out-of-Network Provider. Since the Plan pays 90% after you meet the Annual Deductible, you are responsible for paying the other 10%. This 10% is your Coinsurance.

OUT-OF-POCKET MAXIMUM

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Services. There are separate Network and Out-of-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of- pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Services through the end of the calendar year.

ELIGIBLE EXPENSES

Eligible Expenses are charges for Covered Services that are provided while the Plan is in effect, determined according to the definition in the Glossary.

DON'T FORGET YOUR ID CARD

Remember to show your Anthem BCBS ID card every time you receive health care services from a Provider. If you do not show your ID card, a Provider has no way of knowing that you are enrolled under the Plan.

NETWORK SERVICES

As a Participant of the Plan, you may seek primary prevention or specialty care from any Network Provider without a referral. You and your eligible Dependents may, but are not required to, select a PCP. The Plan encourages you to use your PCP when you need primary or preventive Care. The Plan encourages you to allow your PCP to coordinate your specialty care needs. In this manner, continuity of care can be maintained.

While referrals are not required, any requirements pertaining to Preauthorization, as described in this SPD, must be followed.

To receive the highest level of benefits you must use a network provider. Contact a Network Provider when you need medical assistance. In most instances, he or she will be able to provide the care you need. If you require services from another provider, make sure that he or she is also a Network Provider by checking the roster of Network Providers, or by calling 877-797-2776 or 800-810-BLUE (2583).

Note: It is the member's responsibility to make sure that the provider and / or facility is in the network.

Except for Emergencies, and Preauthorized visits to Out-of-Network Providers, only services provided by a Network Provider are Covered on a Network basis. If a Network Provider cannot perform or deliver the Covered Services you need, you may receive In-Network coverage for Medically Necessary Covered Services from a non- Network Provider. First you must Preauthorize the use of the non-Network Provider. Before Preauthorizing the use of a non-Network Provider for In-Network Covered Services, the Plan may recommend another Network Provider who is able to render the services you need. However, if it is determined that it is necessary for you to use a non-Network Provider (and the services are Preauthorized), there will be no additional cost to you beyond your required Copayment. Additionally, Preauthorization requests for admissions to non-Network facilities (e.g., hospitals, rehabilitation centers) to be Covered on an In-Network basis will not be approved unless it is determined that the Network is unable to meet your specific medical needs, as defined in the SPD. While you and your Network Provider may discuss having a procedure performed at a specific non-Network facility, In- Network coverage is available only if it is determined that the procedure cannot be safely performed at any Network facility. Any non-emergency Covered Services received at a non-Network facility will be subject to the Out-of- Network level of benefits and additional payments by you. If a Network Provider recommends Hospital or surgical services, they will need an approval from preauthorization Vendor before you obtain those services. This process is referred to as Preauthorization. Before entering the Hospital, you must check with Customer Service to verify that the Hospital is a Network Provider and that the services have been Preauthorized.

LOOKING FOR A NETWORK PROVIDER?

In addition to other helpful information, www.anthem.com consumer website, contains a directory of health care professionals and facilities in the Anthem BCBS Network. While Network status may change from time to time, www.anthem.com has the most current source of Network information. Use www.anthem.com to search for Providers available in your Plan. Out-of-Network Services If you decide you do not want to use a Network Provider, the Plan still provides coverage for a broad range of medical services. However, Covered Services not obtained from Network Providers will be subject to Deductible, Coinsurance and Out-of-Network Reimbursement Amounts. Further, Out-of- Network Providers may not be familiar with the Plan. Therefore, you should review the "Covered Services" and "Limitations and Exclusions" sections of this SPD. You may also contact LEA Customer Service if you have any questions concerning Covered Services under this Plan.

Surgical procedures and Hospitalizations still require Preauthorization. You are responsible for obtaining any required Preauthorization. You must call (or have your Physician call) Customer Service to obtain the Preauthorization. Failure to Preauthorize will result in a 50% reduction in benefits.

Network Exceptions: If a Network Provider cannot perform or deliver the Covered Services you need, you may receive Network coverage for Medically Necessary Covered Services from an Out-of-Network Provider. First, you must contact LEA Customer Service and Preauthorize the use of an Out-of-Network Provider. Before Preauthorizing the use of an Out-of-Network Provider for Network Covered Services, the Plan may recommend another Network Provider who is able to render the services you need. However, if the Plan agrees that it is necessary for you to use an Out-of-Network Provider (and Preauthorizes the services), there will be no additional cost to you beyond your required Copayment.

Additionally, Preauthorization requests for admissions to Out-of- Network facilities (e.g., hospitals, rehabilitation centers) to be Covered on a Network basis will not be approved unless the Plan agrees that a Network Provider is unable to meet your specific medical needs. While you and your Network Provider may discuss having a procedure performed at a specific Out-of- Network facility, Network coverage is only available if the Plan agrees that the procedure cannot be safely performed at any Network facility. Any non-emergency Covered Services received at an Out-of-Network facility will be subject to the Out-of-Network level of benefits and will cost you more than covered services received at a Network facility.

PREAUTHORIZATION

All admissions to health care facilities and certain diagnostic tests and therapeutic procedures must be Preauthorized before you are admitted or receive treatment. If you are unsure whether a procedure requires Preauthorization, please call LEA Customer Service Department.

In general, your Provider needs to initiate the approval process by calling the preauthorization vendor before services are rendered. You will receive notification by telephone or in writing no more than three (3) business days after all necessary medical information is received.

To notify the Plan of an admission to a Hospital, the Provider must contact the preauthorization vendor on your ID card.

The following information must always be provided to the preauthorization vendor to satisfy the Preauthorization requirement. The Plan may also require additional information.

- Participant's and Patient's information: Name, Relationship to the Participant, Date of Birth and Address.
- Provider's information: Provider ID number, Tax ID number, Diagnosis code and Procedure code.

Please refer to your plan's Benefits Summary in the Appendix for the list of procedures that must be preauthorized before benefits will be paid.

Important:

1. Preauthorization is required to determine medical necessity and must be obtained before services are rendered.
2. If Preauthorization is obtained and approved by the Preauthorization vendor within 60 days after the date of services, the claim (benefit) will be paid at 100% of applicable benefits. After 61 days, the benefit will be reduced to 50% of the allowed.

Preauthorization starts with a call to the preauthorization vendor's medical management department by the Network Provider involved. One of preauthorization vendor's experienced Medical Management professionals examines the case, consults with your Network Provider and discusses the clinical findings. If all agree, the requested test, procedure or admission is Preauthorized. This comprehensive evaluation insures that the treatment you receive is appropriate for your needs and is delivered in the most cost-effective setting. If your request is not approved, you will be notified of how to appeal the Plan's determination.

Covered inpatient services are Preauthorized for a specific number of days. If your Network Provider believes that a longer stay is Medically Necessary, the extension must be Preauthorized for it to be Covered.

Your Network Provider Initiates Preauthorization but the member is responsible to make sure Preauthorization is obtained. It is ultimately the member's responsibility to make sure preauthorization requests are submitted and approved prior to receiving services. Failure to obtain preauthorization for a service could result in payment reductions for the provider and benefit reductions for the member.

Please remember: Any Preauthorization you receive will not be valid if your coverage under the Plan terminates.

This means that Covered Services received after your coverage has terminated will not be Covered even if they were Preauthorized.

Additionally, Preauthorization is not a guarantee of benefits. The Plan reserves the right to review the Medical Necessity of any services you receive.

SECOND OPINIONS

The Plan reserves the right to require a second opinion for any surgical procedure. At the time of Preauthorization, you may be advised that a second opinion will be required for the services to be Covered. If a second opinion is required, the Plan will refer you to a Network Provider for a second opinion.

If the first and second opinions differ, a third opinion will be required. The Plan will designate a new Network Provider. The third opinion will determine if the surgery is Preauthorized. There will be no cost to you for the second or third opinion required by the Plan. You may also request a second opinion.

EMERGENCIES

If you have an Emergency, you should obtain medical assistance immediately or call 911. Emergency room care is not subject to the Plan's prior approval. However, only Emergencies, as defined in this SPD, are Covered in an Emergency room. Therefore, before you seek treatment, you may want to be certain that this is the most appropriate place to receive care.

URGENT CARE

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is Covered in or out of Our Service Area.

- **In-Network:** You may obtain Urgent Care from a Participating Physician or a Participating Urgent Care Center. You do not need to contact the Plan prior to, or after Your visit.
- **Out-of-Network:** You may obtain Urgent Care from a Non-Participating Urgent Care Center or Physician, but out of network services may incur a higher co-pay.

If Urgent Care results in an Emergency admission, please follow the instructions for Emergency Hospital admissions described above.

DIAGNOSTIC TESTING AND LABORATORY SERVICES

If your Network Provider recommends laboratory testing, remind him or her to use a Network Provider. In addition, Covered X-rays

or diagnostic procedures performed at Network facilities will be Covered by the Plan without any required Copayment. Unless you are hospitalized, Hospitals are not Network Providers for these tests.

CUSTOMER SERVICE

All coverage is subject to the terms and conditions contained in your Plan documents. You should understand your rights and obligations before you obtain services. If you have questions, LEA Customer Service will be pleased to help you.

BALANCE BILLING

In the event that a claim submitted by a Network or non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over non-Network Providers that engage in balance billing practices.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of co-insurances, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

In order to to receive highest level of benefits and avoid unnecessary Balance Billing you must:

- **Stay in-network.** If you visit a doctor or a hospital that is not in your network, you will be responsible for the full cost of your care, in most cases. Use Provider Finder® to find doctors, specialists, hospitals in your network. Register or log in to www.anthem.com for a personalized search experience based on your health plan and network.
- **Find a doctor.** You don't need a referral to see a doctor or other health care professional for a specific health issue, but whoever you choose must be in your plan's network to avoid paying higher out-ofnetwork costs. Check Provider Finder to find an in-network specialist.
- **Get preauthorization.** Certain tests and procedures must be pre-approved before you go as described in your benefit documents. You or your doctor must call the preauthorization (pre-certification) number on the back of your member ID card. Failure to obtain preauthorization for a service could result in payment reductions for the provider and benefit reductions for the member.
- **Use the ER for emergencies only.** If your illness or injury is serious, call 911 or go to the nearest emergency room.
- **Know where to go.** Before you go for a care, make sure you know how your plan works, what's covered and where to go.

CLAIMS AUDIT

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed more than the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this SPD.

More Information: As a Participant, you obtain an SPD at http://www.uswu.org/benefits Please note, you can request additional information about the Plan and your coverage under this SPD.

REIMBURSEMENT (PROVIDER REIMBURSEMENT)

The Plan reimburses our Network Providers in a variety of ways. The most common is a discount off the Provider's usual fee. This means the Provider agrees to accept less than what he or she would usually be paid for that service. In return, the Provider's name appears in Anthem BCBS network, which gives the Provider an opportunity to gain new patients from among our Membership.

PROVIDER PARTICIPATION AND TRANSITIONAL CARE

Provider Participation

The Plan cannot promise that a specific Provider, even though listed in the roster of participating physicians, will be available. A Network Provider may end his or her contract with Anthem BCBS or decide not to accept additional patients. If you have any questions about if a Provider is currently participating or accepting new patients, please feel free to call LEA Member Services. If your PCP or Network Specialist leaves Anthem BCBS Network, you should choose another PCP or Network Specialist to continue receiving care on a Network basis. However, if you are undergoing a course of treatment at the time your Network Provider leaves the Network, you may be eligible for Transitional Care as described below.

Transitional Care

YOUR PROVIDER LEAVES THE NETWORK

If you are undergoing a course of treatment when your Provider leaves the Network, you may be able to continue to receive Covered Services from your former Network Provider. Depending on your condition, you may receive Covered Services for up to 120 days after you receive notification from the Plan that the Provider is no longer in the Network. For pregnancies, if the Provider leaves the Network while you are in your second trimester, you may receive Covered Services through delivery and any post-partum care directly related to the delivery.

Transitional Care is available **only if the provider agrees to accept as payment the Plan's negotiated fees for such services.** Further, the Provider must agree to adhere to all of the Plan's Quality Assurance procedures as well as all other policies and procedures required by the Plan regarding the delivery of Covered Services. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by a Network Provider. You will only be responsible for any applicable Copayments. Pregnancies that are affected by this provision are automatically Covered on a Network basis. You will only be responsible for any applicable Copayments.

Please note: If the Provider was terminated by the Plan due to a quality-of-care issue, Transitional Care is not available.

NEW PARTICIPANTS CURRENTLY UNDERGOING A COURSE OF TREATMENT

If you are undergoing a course of treatment with an Out-of-Network Provider at the time your coverage under this SPD becomes effective, you may be able to receive Covered Services from the Out-of-Network Provider for up to 60 days from the effective date of your coverage under the SPD. This coverage is available only if the course of treatment is for a life-threatening disease/condition or a degenerative and disabling disease/condition. Coverage is limited to the disease/condition. Regarding pregnancy, if your coverage becomes effective while you are in your second trimester, you may receive Covered Services from your Out-of-Network Provider through delivery and any post-partum care directly related to the delivery.

However, Transitional Care is available **only if the Provider agrees to accept as payment** the Plan's **negotiated fees for such services.** Further, the Provider must agree to adhere to all of the Plan's Quality Assurance procedures as well as all other policies and procedures required by the Plan regarding the delivery of Covered Services. If the Provider agrees to these conditions, you will receive these Covered Services as if they are being provided by a Network Provider. You will only be responsible for any applicable Copayments.

To obtain Transitional Care, you should call LEA member services at 1-877-797-7226.

Patient/Provider Relationship

Network Providers are solely responsible for all health services that you receive. If you refuse to follow a recommended treatment, and the Network Provider believes that no professionally acceptable alternative exists, you will be so advised. In such a case, subject to the second opinion process, neither the Plan nor the Network Provider will have any further responsibility to provide care for the condition under treatment.

SECTION 5: PRESCRIPTION BENEFITS

Services and Supplies are provided to Covered Persons and eligible Dependents using the contracted PBM / Rx vendor. Claims for prescription benefits services and supplies are determined by the Claims Administrator, or a delegate that is a pharmacy benefit manager. To use this benefit, simply present your Medical ID Card at any participating pharmacy. If you have any questions regarding whether your pharmacy or any other pharmacy in your area participates, please call Member Helpline on your ID card.

SCHEDULE OF BENEFITS AND PRESCRIPTION CO-PAYMENTS/ CO-INSURANCES

Covered Persons and Eligible Dependents must pay for a part of their prescription drug benefits in the form of a Deductible, Co-Payment or Coinsurance. For each prescription at a participating pharmacy or by mail order, you must pay as listed in your plan's Benefits Summary in the Appendix. Your Cost Sharing is different for generic or brand name prescription drugs.

The Plan allows for the dispensing of up to a 30-day supply as prescribed by the Physician. Members may be able to obtain up to a 90-day supply of generic prescriptions at any pharmacy.

The mail order program was designed to allow Covered Persons and Eligible Dependents to receive large quantities of maintenance medication (e.g., heart medication, blood pressure medication, diabetic medication, etc.). Participants and Eligible Dependents may obtain up to a 90-day supply of their prescription.

COVERED ITEMS

(Coverage may vary depending on the Plan, for specific information please call Rx Member Helpline on your ID Card):

1. AIDS
2. Alcohol Deterrents
3. Antineoplastic/Chemo – Oral an Injectable
4. Bee sting kits
5. Blood / Blood products (Require Preauthorization)
6. Complementary Alternative Medicines
7. Compounded drugs
8. Contraceptives (Injectables, Oral, Patch)
9. Diabetics (Blood Sugar Diagnostics, Insulin, Insulin Syringes, Lancets, Urine Test Strips)
10. CSF/Hematopoietic Agents
11. Fertility Drugs (Require Preauthorization)
12. Fluoride Preps – Oral and Topical
13. Folic Acid
14. Imitrex Injectable w/Std Qty Limit
15. Immunosuppressives
16. Injectables (Require Preauthorization)
17. Interferon Alpha Beta
18. Metabolic Infant Formula (Require Preauthorization)
19. Nutritional Diet Supplies
20. Sexual Dysfunction – Oral and Non-Oral
21. Smoking Deterrent
22. Tuberculin Syringes
23. Vitamins – Prenatal and Non-Prenatal

EXCLUSIONS

(Coverage may vary depending on the Plan, for specific information please call Rx Member Helpline on your ID Card):

In addition to the Exclusions and Limitations applicable to all benefits under the Plan (refer to Section 7), no Prescription Drug benefits are available under this Contract for:

1. Drug or medication which is not a covered maintenance prescription drug;
2. Any charges by any Pharmacy Provider or Pharmacist except as provided herein;
3. Any charge where the Allowable Charge is less than the Participant's or Eligible Dependent's Copayment; and
4. Any charge above the Allowable Charge, advertised, or posted price, whichever is less than the Allowable Charge.
5. Drugs or medications available over-the-counter for which state or federal laws do not require a prescription.
6. Any drugs that are labeled as experimental or investigational.

7. United States Food and Drug Administration (FDA) approved prescriptions drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia, such as The United States Pharmacopoeia (USP) Drug Information, the American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, the Physician Drug Reference (PDR)) or in current medical literature. Medical literature means scientific studies published in peer-reviewed national professional medical journals.
8. Drugs newly approved by the FDA, prior to their review by the Plan's Pharmacy and Therapeutics Committee.
9. Prescription and nonprescription supplies (such as ostomy supplies), devices and appliances other than syringes used in conjunction with injectable medications.
10. Prescriptions covered without charge under federal, state or local programs, including Workers' Compensation
11. Any charge for the administration of a drug or insulin
12. Unauthorized refills
13. Medication for a Participant or Eligible Dependent confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar entity
14. Abortifacients
15. Alcohol Swabs
16. Anabolic steroids
17. Anti-Obesity
18. Biologicals
19. Blood Pressure Supplies
20. Cosmetic Preps
21. Glucometers
22. Hair Growth Stimulants
23. Immune Serums
24. Immunization/Vaccines
25. Miscellaneous Medical Supplies
26. Ostomy Supplies
27. OTC
28. Respiratory Devices
29. X-ray Diagnostics

SECTION 6: COVERED SERVICES

This section includes Covered Services for which the Plan pays Benefits.

You will receive Covered Services in accordance with the terms and conditions of this SPD only when the Covered Service is:

- Medically Necessary;
- Properly Preauthorized, when required;
- Received while your coverage is in force;
- Not excluded under this SPD; and
- Not in excess of the benefit limitations described in this SPD.

All Covered Services are subject to the Copayments, Coinsurance and Deductibles specified under your plan's Benefits Summary in the Appendix. All reimbursement for services rendered by Out-of-Network Providers is subject to Out-of-Network Reimbursement Amounts.

Except for Emergencies or when the Plan Preauthorizes the use of an Out-of- Network Provider **any Covered Service you obtain from an Out-of-Network Provider will be Covered on an Out-of-Network basis.**

Important: The Plan reserves the right to provide benefits in the manner the Plan determines to be the most cost effective. Based on the Plan's medical policies, the Plan reserves the right to provide Benefits in the manner, and to the extent, the Plan believes is Medically Necessary.

PRIMARY AND PREVENTIVE CARE

Primary Care consists of office visits, house calls and Hospital visits provided by your Provider for consultations, diagnosis and treatment of medical conditions, injury and disease that do not require the services of a specialist. Preventive Care consists of the following services, performed by your Provider for promoting good health and early detection of disease.

PREVENTIVE CARE

The Plan pays Benefits for Preventive Care services provided on an outpatient basis at a Physician's office, an alternate facility or a Hospital. Preventive Care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and
- Services Administration (HRSA);
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA; and
- with respect to women, Preventive Care Benefits defined under the HRSA requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. Benefits are only available if breast pumps are obtained from a DME Provider or Physician.

Preventive Care services will be covered at 100% for non-Network Providers if there is no Network Provider who can provide a required preventive service.

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/coverage/preventive-carebenefits/. For more information, Participants may contact the Plan Administrator/Employer. Benefits will be provided for covered services in accordance with Healthcare Reform mandates, including the following:

1. Adult Care and Immunizations

Benefits are provided for routine physical examinations, regardless of Medical Necessity, including a complete medical history, in accordance with a predefined schedule based on age and sex. Covered Persons and Eligible Dependents eighteen (18) years of age and older.

2. Mammographic Screening (includes 3D mammogram screening)

An annual routine mammographic screening for all female Covered Persons and Eligible Dependents forty (40) years of age or older. Mammographic examination for all female Covered Persons and Eligible Dependents regardless of age when such services are prescribed by a Physician.

3. Pediatric Care and Immunizations

Benefits are provided for routine physical examinations, regardless of Medical Necessity. Coverage will be provided to Covered Persons and Eligible Dependents less than twenty-one (21) years of age and covered dependent children for mandated pediatric immunizations. Benefits are exempt from Deductibles or dollar limits.

4. Routine Gynecological Examination and Papanicolaou Smear

Benefits are provided for one (1) routine gynecological examination, including a pelvic examination and clinical breast examination and one (1) routine Papanicolaou Smear per calendar year for all female Covered Persons and Eligible Dependents. Benefits are exempt from all Deductibles or Maximums.

5. Colorectal Cancer Screenings

I. Diagnostic pathology and laboratory screening services such as fecal-occult blood or fecal immunochemical test;

II. Diagnostic x-ray screening services such as barium enema;

III. Surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services; and

IV. Such other diagnostic pathology and laboratory, diagnostic x-ray, surgical screening tests and diagnostic medical screening services consistent with approved medical standards and practices for the detection of colon cancer.

V. For all Covered Persons and Eligible Dependents beginning at age fifty (50) as follows:

- An annual fecal-occult blood test or fecal immunochemical test
- A sigmoidoscopy every five (5) years
- A screening barium enema or test consistent with approved medical standards and practices to detect colon cancer every five (5) years
- A colonoscopy every ten (10) years or more frequently than set forth above and regardless of age when prescribed by a Physician.

For Covered Persons and Eligible Dependents determined to be at high or increased risk, regardless of age.

6. Diabetic Equipment, Supplies and Education

Diabetic Supplies, Education and Self-Management are Covered as follows:

Supplies: The following equipment and related supplies will be Covered for insulin dependent and noninsulin dependent Participants when Medically Necessary as determined by the Participant's Physician:

- Acetone Reagent Strips, Acetone Reagent Tablets, Alcohol Wipes
- All insulin preparations, Automatic Blood Lance Kit, Blood Glucose Kit, Blood Glucose Strips (Test or Reagent)
- Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor (models with special features for the visually impaired must be
- Preauthorized by the Preauthorization Vendor if the cost is greater than $500.)
- Cartridges for the visually impaired Diabetes data management systems, Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the Pump, Glucose Acetone Reagent Strips, Glucose Reagent Strips
- Glucose Reagent Tape Injection Aides
- Injector (Busher) Automatic Insulin Cartridge Delivery
- Insulin Infusion Devices (Preauthorization is required for this item) Insulin Pump
- Lancets
- Oral agents such as glucose tablets or gels, Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones

Additional items may also be Covered if the Participant's Physician determines they are Medically Necessary and prescribes them for the Participant. Such additional items must be Preauthorized by one of preauthorization vendor's Medical Directors and be in accordance with the treatment plan developed by the Physician for the Participant.

Self-Management and Education: Education on self-management and treatment of diabetes is Covered: 1) upon the initial diagnosis; 2) if there is a significant change in the Participant's condition; or 3) the Physician decides that a refresher course is necessary. It must be provided:

- In a Physician's office either by the Physician or his/her qualified nurse during an office visit or in a group setting.
- Upon a Physician's referral to the following non-Physician, medical educators (qualified health providers): certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians.
- Whenever possible, in a group setting, regardless of whether the Provider is a Physician or a qualified health provider. Education will also be provided in the Participant's home if the Participant is homebound.

7. Screening for Prostate Cancer

An annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 40 and up. Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate specific antigen test at any age for men having a prior history of prostate cancer is Covered.

SPECIALTY CARE

Specialty Care consists of medical care and services, including office visits, house calls, Hospital visits and consultations for the diagnosis and treatment of disease or injury as described below.

Please note: Most Specialty Care services require Preauthorization.

A. Surgical and Obstetrical Services

**Preauthorization required for certain services*

Physicians' services for surgical and obstetrical procedures on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant, and anesthetist or anesthesiologist together with preoperative and postoperative care. Deliveries and related services that are performed by a certified nurse midwife are also Covered. Hospital admissions, including maternity admissions, require Preauthorization. When possible, the Preauthorization should be obtained at least 14 days in advance of the service.

B. Maternity and Newborn Care

MATERNITY CARE:

**Preauthorization required for certain services*

Services and supplies for maternity care provided by a Physician, certified nurse midwife, Hospital or birthing center will be Covered for prenatal care (including one visit for genetic testing), postnatal care, delivery and complications of pregnancy. The Plan provides a minimum inpatient stay of 48 hours following a vaginal delivery and 96 hours following a cesarean delivery for both the mother and the newly born child or children.

While in the hospital, maternity care also includes, at a minimum, parent education, assistance and training in breast or bottle-feeding and the performance of any necessary maternal and newborn clinical assessments. Unless the admission to the Hospital or birthing center is made on an Emergency basis, the admission must be Preauthorized.

The mother has the option to leave the hospital sooner than described above. If she decides to be discharged early, she will be provided with one home visit. The home visit must be requested by the mother within 48 hours of a vaginal birth or within 96 hours of a cesarean birth.

The visit will occur within 24 hours of the later of: the mother's request; or her discharge from the hospital. This visit is not subject to deductible or Copayment. Additionally, the visit will not be deducted from the Home Health Care visits covered under the SPD.

The home visit consists of a visit by a professional RN to provide the following post-delivery care: an assessment of the mother and child; instruction on breastfeeding, cleaning and care for child; and any required blood tests ordered by either the mother's or the child's Physician.

Note: Grandchildren are not covered. Any services for a newborn child born to an Eligible Dependent are not covered under the Plan.

INTERRUPTION OF PREGNANCY:

Therapeutic abortions are Covered. Non-therapeutic abortions in cases of rape, incest or fetal malformation are also Covered. One elective abortion per Participant, per calendar year, is Covered subject to the benefit limit listed under Appendices A to O.

NEWBORN CARE:

**Preauthorization required for certain services*

Care for newborns includes preventive health care services (including electrophysiologic screening measures and periodic monitoring of infants for delayed onset of hearing loss), routine

nursery care, and treatment of disease and injury. Treatment of disease and injury includes treatment of prematurity and medically diagnosed congenital defects and birth abnormalities which cause anatomical functional impairment. The Plan also covers, within the limits of this SPD, necessary transportation costs from the place of birth to the nearest specialized treatment center.

In-Network and Out-of-Network routine nursery and preventive Newborn Care does not require Preauthorization. Circumcision performed by a licensed medical practitioner during the delivery inpatient stay does not require Preauthorization. However, services that generally require Preauthorization (such as surgery) must be Preauthorized.

C. Infertility Services

(to see the type of Infertility Services your plan provides please refer to plan's Benefits Summary in the Appendix)

Plan covers diagnostic infertility services to determine the cause of infertility and treatment only when specific coverage is provided under the terms of a member's benefits plan. All coverage is subject to the terms and conditions of the plan. The following discussion is applicable only to members whose plans cover infertility services.

A Person is considered infertile if he or she is unable to conceive or produce conception after 1 year of frequent, unprotected heterosexual sexual intercourse, or 6 months of frequent, unprotected heterosexual sexual intercourse if the female partner is over age 35 years. Alternately, a woman without a male partner may be considered infertile if she is unable to conceive or produce conception after at least 12 cycles of donor insemination (6 cycles for women aged 35 or older up to age 44). (N.Y. Ins. Law §§ 3216(13), 3221(6), and 4303))

Note: coverage is provided for women up to age 44.

Exclusion: infertility services for couples in which either of the partners has had a previous sterilization procedure, with or without surgical reversal, and for females who have undergone a hysterectomy.

BASIC INFERTILITY SERVICES / DIAGNOSTIC SERVICES

Basic Infertility Services consist of: initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram and medically appropriate treatment of ovulatory dysfunction with Clomiphene Citrate.

The following services are considered medically necessary for diagnosis of infertility in females.

A. History and physical examination, basal body temperature

B. Laboratory studies:

1. Anti-adrenal antibodies for apparently spontaneous primary ovarian insufficiency (premature ovarian failure)
2. Anti-sperm antibodies (e.g., immunobead or mixed antiglobulin method)
3. Chlamydia trachomatis screening)
4. Fasting and 2 hours post 75-gram glucose challenge levels
5. Lipid panel (total cholesterol, HDL cholesterol, triglycerides)
6. Post-coital testing (PCT) (Simms-Huhner test) of cervical mucus
7. Rubella serology
8. Testing for viral status (HIV, hepatitis B, hepatitis C)
9. Serum hormone levels

    a. Androgens (testosterone, androstenedione, dehydroepiandrosterone sulfate (DHEA-S) if there is evidence of hyperandrogenism (e.g., hirsuitism, acne, signs of virilization) or ovulatory dysfunction

    b. Anti-mullerian hormone (AMH), for the following indications: a) assessing menopausal status, including premature ovarian failure; b) assessing ovarian status, including ovarian reserve and ovarian responsiveness, as part of an evaluation for infertility and assisted reproduction protocols such as in vitro fertilization.

    c. Gonadotropins (serum follicle-stimuating hormone [FSH], luteinizing hormone [LH]) for women with irregular menstrual cycles

    d. Prolactin for women with an ovulatory disorder, galactorrhea, or a pituitary tumor

    e. Progestins (progesterone, 17-hydroxyprogesterone) (see Appendix for medical necessity limitations)

    f. Estrogens (estradiol)

    g. Thyroid stimulating hormone (TSH) for women with symptoms of thyroid disease

    h. Adrenocortitrophic hormone (ACTH) for ruling out Cushing's syndrome or Addison's disease in women who are amenorrheic

    i. Clomiphene citrate challenge test

10. Karyotype testing for couples with recurrent pregnancy loss (2 or more consecutive spontaneous abortions)

C. Diagnostic procedures:

1. CT or MR imaging of sella turcica is considered medically necessary if prolactin is elevated
2. Endometrial biopsy
3. Hysterosalpingography (hysterosalpingogram (HSG)) or hysterosalpingo-contrast-ultrasonography to screen for tubal occlusion. Note: Sonohysterosalpingography or saline hysterosalpingography (e.g., Femvue) are considered experimental and investigational to screen for tubal occlusion because of a lack of reliable evidence of effectiveness.
4. Hysteroscopy, salpingoscopy (falloscopy), hydrotubation where clinically indicated
5. Laparoscopy and chromotubation (contrast dye) to assess tubal and other pelvic pathology, and to follow-up on hysterosalpingography abnormalities
6. Sonohysterography to evaluate the uterus
7. Ultrasound (e.g., ovarian, transvaginal, pelvic)
8. Monitoring of ovarian response to ovulatory stimulants:
   a. Estradiol
   b. FSH
   c. hCG quantitative
   d. LH assay
   e. Progesterone
   f. Serial ovarian ultrasounds are considered medically necessary for cycle monitoring.

The following services are considered medically necessary for diagnosis of infertility in males.

A. History and physical examination

B. Laboratory studies:

1. Anti-sperm antibodies (e.g., immunobead or mixed antiglobulin method)
2. Cultures
   a. Prostatic secretion
   b. Semen
   c. Urine
3. Serum hormone levels
   a. 17-hydroxyprogesterone
   b. Adrenal cortical stimulating hormone (ACTH)
   c. Androgens (testosterone, free testosterone) - if initial testosterone level is low, a repeat measurement of total and free testosterone as well as serum luteinizing hormone (LH) and prolactin levels is medically necessary
   d. Estrogens (e.g., estradiol, estrone)
   e. Gonadotropins (FSH, LH)
   f. Growth hormone (GH)
   g. Prolactin for men with reduced sperm counts, galactorrhea, or pituitary tumors
   h. Sex hormone binding globulin (SHGB) for men with signs and symptoms of hypogonadism and low normal testosterone levels. (SHGB is not indicated in the routine evaluation of male infertility)
   i. Thyroid stimulating hormone (TSH) for men with symptoms of thyroid disease.
4. Semen analysis (volume, pH, liquefaction time, sperm concentration, total sperm number, motility (forward progression), motile sperm per ejaculate, vitality, round cell differentiation (white cells versus germinal), morphology, viscosity, agglutination) is considered medically necessary for the evaluation of infertility in men. Because of the marked inherent variability of semen analyses, an abnormal result should be confirmed by at least one additional sample collected one or more weeks after the first sample.
   - For men with abnormal semen analysis exposed to gonadotoxins, up to 4 semen analyses are considered medically necessary.
   - For men with a normal initial semen analysis, a repeat semen analysis is considered medically necessary if there is no pregnancy 4 months after the initial normal semen analysis.
   - If the result of the first semen analysis is abnormal and the man has not been exposed to gonadotoxins, up to 2 repeat confirmatory tests may be considered medically necessary.
5. Vasography

6. Semen leukocyte analysis (e.g., Endtz test, immunohistochemical staining)
7. Seminal fructose
   Note: Seminal alpha-glucosidase, zinc, citric acid, and acid phosphatase are considered experimental and investigational.
8. Blood test for cytogenetic analysis (karyotype and FISH) in men with severe deficits of semen quality or azoospermia (for consideration of ICSI)
9. Cystic fibrosis mutation testing in men with congenital absence of vas deferens
10. Y chromosome microdeletion analysis in men with severe deficits of semen quality or azoospermia (for consideration of ICSI).
    Note: Y chromosome microdeletion analysis is not routinely indicated before ICSI, and is subject to medical necessity review
11. Post-coital test (PCT) (Simms-Huhner test) of cervical mucus
12. Sperm function tests including Sperm penetration assay (zona-free hamster egg penetration test)

COMPREHENSIVE INFERTILITY SERVICES

In addition to the services described in the Basic Infertility Service above, these services include: ovulation induction and monitoring with ultrasound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.

The following services are considered medically necessary for treatment of infertility in females:

1. Hysteroscopic adhesiolysis for women with amenorrhea who are found to have intrauterine adhesions
2. Hysteroscopic or fluoroscopic tubal cannulation (salpingostomy, fimbrioplasty), selective salpingography plus tubal catheterization, or transcervical balloon tuboplasty for women with proximal tubal obstruction
3. Laparoscopic cystectomy for women with ovarian endometriomas
4. Laparoscopy for treatment of pelvic pathology
5. Open or laparoscopic resection, vaporization, or fulguration of endometriosis implants plus adhesiolysis in women with endometriosis
6. Ovarian wedge resection or ovarian drilling for women with WHO Group II ovulation disorders such as polycystic ovarian syndrome who have not responded to clomiphene citrate
7. Removal of myomas, uterine septa, cysts, ovarian tumors, and polyps
8. Surgical tubal reconstruction (unilateral or bilateral tubal microsurgery, laparoscopic tubal surgery, tuboplasty and tubal anastomosis) for women with mid or distal tubal occlusion and for women with proximal tubal disease where tubal cannulation has failed or where severe proximal tubal disease precludes the likelihood of successful cannulation
9. Tubal ligation (salpingectomy) for women with hydrosalpinges who are contemplating in vitro fertilization, as this has been demonstrated to improve the chance of a live birth before in-vitro fertilization treatment
10. Cervicectomy/trachelectomy is an acceptable alternative to hysterectomy for treatment of early stage (IA2 or small IB1) cervical adenocarcinoma in women who wish to preserve their fertility.

The following services are considered medically necessary for treatment of infertility in males:

1. Varicocelectomy (spermatic vein ligation)
2. Spermatocelectomy and hydrocelectomy
3. Surgical correction of epididymal blockage for men with obstructive azoospermia.
   a. Epididymectomy
   b. Excision of epididymal tumors and cysts
4. Transurethral resection of ejaculatory ducts (TURED) for obstruction of ejaculatory ducts
5. Orchiopexy
   Note: reversal of sterilization not covered

ARTIFICIAL INSEMINATION:

A. Artificial Insemination (intra-cervical insemination or intra-uterine insemination [IUI]) is considered medically necessary for infertile couples with mild male-factor fertility problems, unexplained infertility problems, minimal to mild endometriosis, medically refractory erectile dysfunction or vaginismus preventing intercourse, couples where the man is HIV positive and undergoing sperm washing, or couples undergoing menotropin ovarian stimulation.

B. Clomiphene-Citrate-Stimulated Artificial Insemination (intra-cervical insemination or IUI) is considered medically necessary for infertile women with WHO Group II ovulation disorders such as polycystic ovarian syndrome who ovulate with clomiphene citrate but have not become pregnant after ovulation induction with clomiphene.

C. Electroejaculation is considered medically necessary DME to overcome total anejaculation secondary to neurologic impairment, which most commonly occurs among members with the following conditions:

1. Diabetic neuropathy
2. Prior retroperitoneal surgery (most commonly retroperitoneal lymphadenectomy as a treatment of testicular cancer)
3. Spinal cord injury.

D. Donor insemination is considered medically necessary for the following indications:

1. Non-obstructive azoospermia
2. Obstructive azoospermia
3. Severe deficits in semen quality in couples who do not wish to undergo intracytoplasmic sperm injection (ICSI)
4. Severe rhesus isoimmunization
5. Where there is a high risk of transmitting a genetic disorder in the male partner to the offspring.
6. Where there is a high risk of transmitting an infectious disease (such as HIV) to the partner or offspring.

Note: coverage is limited to six (6) cycles per lifetime.

Exclusions: donor insemination would not be covered for these indications: infectious disease in male partner, high risk of transmitting a genetic disorder, as these do not meet the definition of infertility. The plans that otherwise cover infertility services exclude coverage of fees associated with donor insemination (including semen donor recruitment, selection and screening, and cryostorage of sperm). In addition, cryopreservation of semen not covered as it is not considered treatment of disease.

ADVANCED INFERTILITY SERVICES
**Preauthorization required for Advanced Reproductive Technology (ART) services*

In addition to the services described in the Basic and Comprehensive Infertility Service these services include Advanced Reproductive Technology (ART): in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).

Note: coverage is limited to four (4) cycles per lifetime.

ADVANCED REPRODUCTIVE TECHNOLOGY
The following Advanced Reproductive Technologies (ART) procedures are considered medically necessary for women with infertility that meet any of the following criteria:

A. Women who have failed to conceive after a trial of ovarian stimulation:

1. For women 37 years of age or younger, six cycles of ovarian stimulation (with or without intrauterine insemination);
2. For women 38 to 39 years of age, three cycles of ovarian stimulation (with or without IUI);
3. For women 40 years of age or older up to age 44, no trial of ovarian stimulation is required;

B. Couples for whom natural or artificial insemination would not be expected to be effective and ART would be expected to be the only effective treatment, including:

1. Men with azoospermia or severe deficits in semen quality or quantity;
2. Women with tubal factor infertility:
   a. Bilateral tubal disease (e.g., tubal obstruction, absence, or hydrosalpinges).
   b. Endometriosis stage 3 or 4.
   c. Failure to conceive after pelvic surgery with restoration of normal pelvic anatomy:
      i. After trying to conceive for 6 months if less than 40 years of age;
      ii. After trying to conceive for 3 months if 40 years of age or older up to age 44.
   d. Infertility resulting from ectopic pregnancy
   e. Ectopic pregnancy occurring during infertility treatment.
   f. Unilateral hydrosalpinx with failure to conceive:
      i. After trying to conceive for 12 months if less than 40 years of age;
      ii. After trying to conceive for 6 months if 40 years of

age or older up to age 44.

3. Inadvertent ovarian hyperstimulation (estradiol level was greater than 1,000 pg/ml plus greater than 3 follicles greater than 16 mm or 4 to 8 follicles greater than 14 mm or a larger number of smaller follicles) during preparation for a planned stimulated cycle in women less than 40 years of age.
   Note: Coverage is limited to plans with an ART benefit; please check benefit plan descriptions in the Appendices A to O).

C. In-Vitro Fertilization (IVF) with embryo transfer is considered medically necessary when criteria for ART are met. IVF with embryo transfer includes:

1. Embryo transfer (transcervical transfer back to the donor) (including cryopreserved embryo transfer)
2. Frozen embryo transfer (FET)
   Note: It may be considered medically necessary to freeze embryos not transferred during a stimulated IVF treatment cycle, and to transfer the embryos before the next stimulated treatment cycle because this will minimize ovulation induction and egg collection, both of which carry risks for the woman and use more resources. Before proceeding to a fresh ART oocyte, previously frozen oocytes must be used (i.e. fertilized and transferred). Similarly, before proceeding to the next fresh ART cycle, FET using cryopreserved embryos must be used if an adequate number of cryopreserved embryos of a similar developmental stage are available
3. Oocyte (egg) insemination in laboratory dish
4. Oocyte (egg) retrieval via laparoscope or transvaginal needle aspiration of follicles, limited to 4 egg retrievals per lifetime
5. Sperm preparation and capacitation
6. Intra-cytoplasmic sperm injection (ICSI) is medically necessary where there is azoospermia or oligospermia (obstructive or non-obstructive), severe deficits in semen quality or quantity to fertilize frozen oocytes for in vitro fertilization, or for couples where a previous IVF treatment cycle has resulted in failed or poor fertilization.
7. Assisted hatching is considered medically necessary for any of the following indications:
   a. Age greater than 38 years up to age 44;
   b. Multiple (2 or more) failed IVF attempts;
   c. Thickened zona pellucida.
8. IVF cycles using either fresh or previously frozen oocytes are considered medically necessary when the ART cycle is considered medically necessary.

D. Gamete Intra-Fallopian Transfer (GIFT) is considered medically necessary as an alternative to IVF for women with female factor infertility. GIFT includes:

1. Immediate loading of the eggs into a transfer catheter with sperm and insertion into the member's fallopian tube via the same laparoscope (the member must have at least 1 patent fallopian tube for this method to be an effective treatment for infertility)
2. Oocyte (egg) retrieval via laparoscope, limited to 4 egg retrievals per lifetime

Note: GIFT is considered experimental and investigational for person with male factor infertility or unexplained infertility problems because there is insufficient evidence to recommend GIFT over IVF for these indications.

E. Zygote intra-fallopian transfer (ZIFT), tubal embryo transfer (TET), pronuclear stage tubal embryo transfer (PROUST) is considered medically necessary as an alternative to IVF for women with female factor infertility.
Note: ZIFT is considered experimental and investigational for persons with male factor infertility or unexplained infertility problems because there is insufficient evidence to recommend ZIFT over IVF for these indications.

F. Specialized Sperm Retrieval Techniques (including vasal sperm aspiration, microsurgical epididymal sperm aspiration (MESA), percutaneous epididymal sperm aspiration (PESA), electroejaculation, testicular sperm aspiration (TESA), microsurgical testicular sperm extraction (TESE), seminal vesicle sperm aspiration, and sperm recovery from bladder or urine for retrograde ejaculation) are considered medically necessary to overcome anejaculation or azoospermia.
Note: plans exclude coverage of infertility services for persons who have undergone sterilization. This would include sperm retrieval for men who have undergone vasectomy.

G. Oocyte Donation is considered medically necessary for managing infertility problems associated with the following conditions, when the infertile member is the intended recipient of the resulting embryos:

1. Bilateral oophorectomy;

2. Gonadal dysgenesis including Turner syndrome;
3. High-risk of transmitting a genetic disorder from the female partner to the offspring;
4. IVF treatment failure
5. Ovarian failure following chemotherapy or radiotherapy; or
6. Premature ovarian failure (failure of ovulation in woman younger than 40 years of age)
(considered medically necessary until the woman with POF is 45 years of age).

Note: plan excludes coverage of fees associated with oocyte donation, including recruitment and selection of donors, ovarian stimulation of donors, collection of oocytes from donors, and screening and storage of donor oocytes. Under plans with benefits for IVF that have this exclusion, medically necessary IVF services are covered only once an embryo is created from the donor egg.

H. Cryopreservation of Mature Oocytes or Embryos is considered medically necessary for use in women facing iatrogenic infertility due to chemotherapy, pelvic radiotherapy, other gonadotoxic therapies or ovary removal for treatment of disease. Routine use of oocyte cryopreservation in lieu of embryo cryopreservation, oocyte cryopreservation to circumvent reproductive aging in healthy women, cryopreservation of immature oocytes, and laser-assisted necrotic blastomere removal from cryopreserved embryos are considered experimental and investigational.
Note: plan excludes coverage of any charges associated with embryo cryopreservation or storage of cryopreserved embryos. Cryopreservation of embryos and oocytes (other than short-term cryopreservation of embryos that are necessary for contemporaneous use in infertile persons currently under active fertility treatment or use of cryopreserved embryos or mature oocytes in women facing infertility due to chemotherapy or other gonadotoxic therapies or gonad removal) is not considered treatment of disease and is not covered.

I. Cryopreservation of Sperm is considered medically necessary in men facing iatrogenic infertility due to chemotherapy, pelvic radiotherapy, other gonadotoxic therapies, or testicular removal for treatment of disease. Sperm cryopreservation to circumvent reproductive aging in healthy men is considered experimental and investigational.
Note: plan excludes coverage of any charges associated with sperm cryopreservation or storage. Cryopreservation of sperm (other than cryopreserved sperm in men facing infertility due to chemotherapy or other gonadotoxic therapies or gonad removal) is not considered treatment of disease and is not covered.

J. The following procedures are considered experimental and investigational:

1. Determination of CAG-repeat polymorphisms in the polymerase γ (POLG) gene for evaluation of male infertility
2. Early Embryo Viability Assessment (Eeva) test
3. EmbryoGlue
4. Germ cell transplantation or cultured testicular stem cells
5. Hyperbaric oxygen therapy for the treatment of male infertility
6. Partial zonal dissection (PZD)
7. Preimplantation genetic screening for IVF optimization Subzonal sperm insertion (SUZI)

Note: A cycle of ART defined in the CPB may be any of the following: IVF (with fresh embryos), IVF/frozen embryo transfer, GIFT or ZIFT.

Note on elective single embryo transfer: In order to reduce the number of high-order multiple pregnancies, current guidelines from the American Society for Reproductive Medicine (ASRM, 2009) recommend elective single embryo transfer for women under the age of 35 who have no prior IVF cycles or who have had a previous IVF cycle that was successful in producing a pregnancy (i.e., documentation of fetal heartbeat) and who have excess embryos of sufficient quality to warrant cryopreservation. For women who meet these criteria who elect transfer of a single fresh embryo, the Plan Administrator will consider transfer of one (1) cryopreserved embryo immediately subsequent to the fresh embryo transfer as part of the same IVF cycle, under plans that limit the number of IVF cycles that are covered.

D. Allergy Testing and Treatment

The Plan Covers testing and evaluations to determine the existence of an allergy. Routine allergy injections, including serums are Covered. The Plan also covers immunizations, but not if solely for the purpose of travel or as a requirement of a Covered Person's employment.

E. Nutritional Counseling

The Plan covers charges for nutritional counseling for the management of a medical condition that has specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner. This section does not apply to nutritional counseling related to "Diabetes Benefits".

F. Rehabilitation Services

**Preauthorization required for inpatient admissions*

Rehabilitation therapy, including physical therapy, speech therapy, and occupational therapy, is Covered on an outpatient or inpatient basis. Coverage on an outpatient basis is limited to the number of visits shown in your plan's Benefits Summary in the Appendix. Admission to a Rehabilitation Facility requires Preauthorization. For the purposes of this benefit (both inpatient and outpatient), "per condition" means the disease or injury causing the need for the therapy. For Covered Services received under this benefit you are eligible to receive up to the specified amount for the singular condition as noted in your plan's Benefits Summary in the Appendix. The accumulation of this limit is based on the "condition" and not the therapy type. Unrelated conditions are subject to separate maximums. A "session" is a period, up to 45 minutes, in which therapy is performed.

Speech or occupational therapy is Covered only when it is necessary to correct a condition that is the result of a disease, injury or a congenital defect for which surgery has been performed.

Covered Services must begin within six months of the later to occur:

- the date of the injury or illness that caused the need for the therapy;
- the date the Participant is discharged from a Hospital where surgical treatment was rendered; or
- the date outpatient surgical care is rendered.

And in no event will the therapy continue beyond 365 days after such event.

Benefits will be provided for the following Covered Services only when such Services are Preauthorized and ordered by a Physician:

- **Cardiac Rehabilitation** benefits will be provided for all Phases on an outpatient or inpatient basis.
- **Chemotherapy** benefits will be provided when performed by a facility/office provider and for selfadministration if the components are furnished and billed by a facility/office provider.
- **Dialysis** treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
- **Infusion Therapy** benefits will be provided when performed by a facility/office provider and for selfadministration if the components are furnished and billed by a facility/office provider.
- **Radiation Therapy** is covered on an outpatient or inpatient basis.
- **Respiratory Therapy** is covered on an outpatient or inpatient basis.
- **Therapeutic Injections** required in the diagnosis, prevention and treatment of an injury or illness.

**Preauthorization required*

Hyperbaric Oxygen Therapy (HBOT) is covered when medically necessary for treatment of following conditions:

- Acute peripheral arterial insufficiency;
- Acute thermal burns: deep second degree or third degree in nature;
- Acute traumatic ischemia;
- Carbon monoxide poisoning;
- Central retinal artery occlusion (CRAO);
- Cyanide poisoning;
- Chronic non-healing wounds which have not responded to 30 days of appropriate conservative treatment and which show continued response when evaluated at 30-day intervals;
- Chronic refractory osteomyelitis (refractory osteomyelitis);
- Compartment syndrome;
- Compromised skin graft or flaps (enhancement of healing in selected wounds);
- Crush injuries;
- Decompression sickness;
- Delayed radiation injury, including osteoradionecrosis, soft tissue radiation necrosis, and radiation cystitis;
- Gas or air embolism;
- Gas gangrene (for example, clostridial myositis and myonecrosis);

- Intracranial abscess;
- Necrotizing soft-tissue infections;
- Prophylactic pre and post treatment for individuals undergoing dental surgery of a radiated jaw; or
- Severe anemia with exceptional blood loss: when transfusion is impossible or delayed.

Plan does not include coverage for investigational and not medically necessary services: If the wound fails to show measurable signs of healing within 30 days of initiating and at each subsequent 30-day interval of systemic hyperbaric oxygen pressurization; Topical hyperbaric oxygen; Limb specific hyperbaric oxygen pressurization; Systemic hyperbaric oxygen pressurization. Please refer to your plan's Benefits Summary in the Appendix for specific out of pocket expenses.

G. Reconstructive and Corrective Surgery

** Preauthorization required for inpatient admissions*

Reconstructive and corrective surgery is Covered only when:

- It is performed to correct a congenital birth defect of an infant who was born while Covered under this SPD; or
- Is incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part.

The reconstructive or corrective surgery must be performed within two years of the surgery that was necessitated by the trauma, infection or disease.

Breast reconstruction (including surgery on the healthy breast to restore and achieve symmetry) or implanted breast prostheses are also Covered following a Covered mastectomy. Cosmetic surgery is not Covered.

H. Online Doctor visits

Live Online video chat with licensed doctors provided by Anthem Blue Cross Blue Shield at: https://livehealthonline.com/ or on the phone at: 1-888-548-3432.

I. Oral Surgery

General dental services are not Covered. The following limited dental and oral surgical procedures are Covered in either an inpatient or outpatient setting:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to "accidental injury." Replacement is Covered only when the repair is not possible. Dental services must be obtained within 12 months of the injury. "Accidental injury" does not include damage caused to a tooth while biting or chewing or the intentional misuse of the tooth.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for TMJ and orthognathic surgery may be Covered if Preauthorized and approved by preauthorization vendor's Medical Director.

Oral Surgery, including the dental services described above, requires Preauthorization. When possible, please obtain the Preauthorization at least 14 days in advance of the surgery or procedure.

J. Laboratory Procedures and X-ray Examinations

X-ray and laboratory procedures, services and materials, including diagnostic X-rays, X-ray therapy, fluoroscopy, electrocardiograms, laboratory tests, and therapeutic radiology services are Covered when performed on an outpatient basis.

Major diagnostic procedures require Preauthorization. It is important that you do not seek the services of a laboratory or imaging center without Preauthorization. If you do, you will be responsible for the costs of such services. Please contact preauthorization vendor's Medical Management Coordination before you obtain any of the procedures listed in your plan's Benefits Summary in the Appendix.

Benefits will be provided for the following Covered Services only when such Covered Services are ordered by a Professional Provider:

1. Diagnostic pathology, consisting of laboratory and pathology tests;
2. Diagnostic X-ray consisting of radiology, ECG, EEG, Ultrasound, Polysomnography; Preauthorization Required for Polysomnography.
3. Diagnostic Imaging (MRI, CT Scan, PET, MRA, Nuclear Stress Testing), Preauthorization required

4. DNA-Testing covered as pathology testing, Preauthorization required

Note: Independent Clinical Laboratory must be located in the same state as referring provider. Claims must be filed to the plan in whose state the specimen was drawn. (i.e. Patient has blood drawn in New York, sample is sent to lab in New Jersey, Lab claim must be submitted to New York). Where the specimen was drawn will be determined by which state the referring provider is located.

K. Internal and External Prosthetic Devices

Internal Prosthesis: Surgically implanted prosthetic devices and special appliances will be Covered if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a Covered mastectomy. Coverage also includes repair and replacement due to normal growth or normal wear and tear. Coverage does not include artificial organs.

External Prosthetic Devices: The Plan Covers prosthetic devices that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. For adults, the Plan Covers the cost of only one prosthetic device per lifetime. For children, the cost of replacements is also Covered but only if the previous device has been outgrown. Purchase of the device must be Preauthorized. Coverage is for standard equipment only. The Plan does not otherwise Cover the cost of repairs or replacement.

External breast prostheses following a Covered mastectomy are also Covered.

Wigs: The Plan covers the wigs, if needed due to a specific diagnosis of chemotherapy induced alopecia. Coverage is limited to one per calendar year, please refer to your plan's Benefits Summary in the Appendix for any limitations and Cost-Sharing requirements.

Orthotic Devices: Custom Molded Shoe inserts covered if prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed medically necessary. Coverage does not include diabetic shoes, orthopedic shoes and arch supports.

Preauthorization Required: Preauthorization is required when the item will cost $500.00 or more.

L. Durable Medical Equipment and Braces

**Preauthorization is required for all rentals and purchases of $500 or more*

Durable Medical Equipment. The Plan Covers Durable Medical Equipment. Durable Medical Equipment is equipment which is: 1) designed and intended for repeated use; 2) primarily and customarily used to serve a medical purpose; 3) generally not useful to a person in the absence of disease or injury; and 4) is appropriate for use in the home.

Coverage is for standard equipment only. The Plan does not Cover customization of any item of Durable Medical Equipment. All maintenance and repairs that result from a Participant's misuse are the Participant's responsibility. The decision to rent or purchase such equipment will be made solely at the Plan's discretion.

Braces. The Plan Covers braces that are worn externally and that temporarily or permanently assists all or part of an external body part function that has been lost or damaged because of an injury, disease or defect.

Coverage is for standard equipment only. Replacements are Covered when growth or a change in the Participant's medical condition make replacement Medically Necessary. The Plan does not otherwise Cover the cost of repairs or replacement (e.g., the Plan does not Cover repairs or replacement that is the result of misuse or abuse by the Participant).

Preauthorization Required: Preauthorization for the purchase of Durable Medical Equipment or braces is required when the item will cost $500.00 or more.

Note: DME Claims must be filed to the plan in whose state shipment was delivered. (i.e. Provider is located in Florida, DME was shipped to a patient in New York, DME claim must be submitted to New York).

M. Medical Supplies

The Plan Covers medical supplies that are required for the treatment of a disease or injury which is Covered under this SPD. Maintenance supplies (e.g., ostomy supplies) are also Covered for conditions Covered under this SPD. All such supplies must be Medically Necessary and in the appropriate amount for the treatment or maintenance program in progress. Diabetic Supplies are not Covered under this provision.

Compression stockings are a covered service when there is a medical indication present, warranted for those covered services. Surgical stockings are covered when ordered by a prescriber to prevent embolisms in the legs of non-ambulatory (e.g., bed-confined) consumers. Coverage of compression garments is limited to the following diagnoses:

- Lymphedema
- Elephantiasis

- Milroy's disease
- Orthostatic hypotension
- Pregnancy with associated symptomatic venous insufficiency
- Stasis dermatitis
- Stasis ulcers
- Symptomatic chronic venous insufficiency (for example, pain, swelling, ulcers, severe varicose veins)
- Thrombophlebitis
- Post-thrombotic syndrome Surgical stockings are specialized stockings covered when ordered by a prescriber to prevent embolisms in the legs of non-ambulatory (e.g., bed-confined) consumers

Coverage is limited to six or three pairs per calendar year depending on procedure and diagnosis.

Plan does not include coverage for garter belt and non-elastic wrap.

N. Transplants

The Plan Covers only those transplants that the preauthorization vendor determines to be nonexperimental and non- investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, pancreas, lung transplants; and bone marrow/stem cell transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by your Specialist(s) and Preauthorized. Additionally, all transplants must be performed at Nationally Accredited Facilities that the preauthorization vendor has specifically approved and designated to perform these procedures. All other facilities will be considered as Out-of- Network. In addition to the approval and designation by the preauthorization vendor, the Plan Administrator must approve the facility for the transplant.

The Plan will cover the Hospital and medical expenses, including donor search fees, of the recipient.

The Plan will cover autologous bone marrow transplants combined with high dose chemotherapy when medically appropriate, for the treatment of: advance neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, and metastatic breast cancer or any other diagnosis that preauthorization vendor's Medical Advisory Board determines to be medically appropriate.

Subject to the provisions of the Plan, benefits will be provided for covered services furnished by a Hospital which are directly and specifically related to the transplantation of organs, bones, tissues or blood stem cells.

If a human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:

1. When both the recipient and the donor are Covered Persons or Eligible Dependents, each is entitled to the benefits under the Plan;
2. When only the recipient is covered, both the donor and the recipient are entitled to the benefits subject to the following additional limitations:
   a. 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 any government program; and
   b. Benefits provided to the donor will be charged against the recipient's coverage to the extent that benefits remain and are available after benefits for the recipient's own expenses have been paid.
3. When only the donor is a Participant or Eligible Dependent, the donor is entitled to the benefits under the Plan, subject to the following additional limitations:
   a. The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Contract, and
   b. No benefits will be provided to the non-Participant or Eligible Dependent transplant recipient;
4. If any organ, tissue or blood stem cell is sold rather than donated to the Participant or Eligible Dependent recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the Participant or Eligible Dependent Recipient's Plan limits.

The Plan does not Cover travel expenses, lodging, meals or other accommodations for donors or guests.

O. Home Health Care

**Preauthorization required*

The Plan Covers care provided in your home by a home health service or agency licensed by the appropriate state agency.

The care must be provided by Physician-supervised health professionals pursuant to Your Physician's written treatment plan

and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes (i) part-time or intermittent nursing care by or under the supervision of a registered professional nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational, or speech therapy provided by the home health service or agency, and (iv) medical supplies, drugs and medications prescribed by a Network Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a hospitalization or confinement in a Skilled Nursing Facility.

Benefits will be provided when performed by a licensed Home Infusion Therapy Provider in a home setting. This benefit includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with Home Infusion Therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with Home Infusion Therapy.

Home Health Care combined with Home Infusion Therapy is limited to the number of visits shown in your plan's Benefits Summary in the Appendix. Each visit of up to two hours by a registered nurse or therapist is one visit. Each visit up to four hours by a home health aide is one visit.

P. Chemotherapy

**Preauthorization required when performed as Outpatient Hospital Services in an Out of Network facility*

Chemotherapy is Covered on an inpatient basis in a Hospital or Skilled Nursing Facility, through Home Health care or on an outpatient basis in an outpatient facility. Chemotherapy is also Covered when provided in a Network Physician's office.

Q. Second Opinions

There may be instances when you will disagree with a Provider's recommended course of treatment. In such cases, you may request that preauthorization vendor designate another Provider to render a second opinion. If the first and second opinions do not agree, preauthorization vendor will designate another Provider to render a third opinion. After completion of the second opinion process, preauthorization vendor will Pre-certify Covered Services supported by most of the Providers reviewing your case. You must pay any Copayment for a second opinion that you request.

If the first opinion concerns a diagnosis of cancer (either negative or positive) or treatment for cancer, you may obtain a second opinion from an Out-of-Network Provider on a Network basis.

Please note: Providers who render a second or third opinion cannot perform the Preauthorized service. If preauthorization vendor Preauthorizes a service that is recommended by the second (or second and third) Provider, you will be asked to select another Provider to perform the actual service.

A second opinion may be required before preauthorization vendor Preauthorizes a surgical procedure. There will be no cost to you when preauthorization vendor requests a second opinion.

R. Chiropractic Services

The Plan will cover spinal subluxation and related services when performed by a Doctor of Chiropractic ("Chiropractor"). This includes assessment, manipulation and any modalities.

This benefit remains subject to Medically Necessity. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this SPD.

Please refer to your plan's Benefits Summary in the Appendix for any Limitations and Cost-Sharing requirements.

S. Clinical Trials for Cancer or Disabling or Life-Threatening Disease

The Plan will not deny any Qualified Individual the right to participate in an Approved Clinical Trial, as those terms are defined in the federal Public Health Service Act, Section 2709. An Approved Clinical Trial is generally a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other Life-Threatening Condition and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or is exempt from investigational new drug application requirements. A Life-Threatening Condition for this purpose is a disease or condition likely to result in death unless the disease or condition is interrupted.

A Qualified Individual is a Plan participant or covered dependent who is eligible, according to the trial protocol, to participate in an Approved Clinical Trial for the treatment of cancer or other Life-Threatening Condition and either:

- the referring health care professional is a participating provider and has concluded that the participant's or beneficiary's participation in the clinical trial would be appropriate; or
- the participant or covered dependent provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

The Plan will not deny, limit, or impose additional conditions

on the coverage of Routine Patient Costs for items and services furnished in connection with participation in the approved clinical trial. Routine Patient Costs include items and services typically provided under the Plan for a participant not enrolled in a clinical trial. However, such items and services do not include (a) the investigational item, device or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the diagnosis.

The Plan reserves the right to require a Qualified Individual to use an in-network provider participating in an Approved Clinical Trial if the provider will accept the individual as a participant. The Plan will not discriminate against any Qualified Individual who participates in an Approved Clinical Trial.

Please remember, the Covered Service must be Preauthorized.

T. Habilitation Services

The Plan Covers Habilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office. Refer to your Schedule of Benefits to determine if a limit applies to your plan.

Please refer to your plan's Benefits Summary in the Appendix for any Limitations and Cost-Sharing requirements.

U. Hearing Aids

The Plan Covers hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered services are available for a hearing aid that is purchased because of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. The Plan Covers a single purchase (including repair and/or replacement) of hearing aids for one or both ears once every three years.

Bone anchored hearing aids are Covered only if You have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

If You meet the criteria for a bone anchored hearing aid, Coverage is provided for one hearing aid per ear during the entire period that You are enrolled under this Certificate. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions. Please refer to your plan's Benefits Summary in the Appendix for any Limitations and Cost-Sharing requirements.

V. Hospital and Other Facility-Based Services

Please remember, in order to receive coverage for any facility based Covered Service, the Covered Service must be Preauthorized.

W. Hospital Services (Excluding Mental Health Services, Alcohol and Substance Abuse)

**Hospital admissions require Preauthorization. All Preauthorized admissions to Network Hospitals are Covered on a Network basis; regardless of whether or not the admitting Provider is a Network Provider.*

Inpatient Services: Coverage for Hospital Inpatient services for Medically Necessary, **acute-care** includes: semi-private room and board, unlimited days, general nursing care and the following additional facilities, services and supplies: meals and special diets; use of operating room and related facilities; use of intensive care or cardiac care units and related services; X-ray services; laboratory and other diagnostic tests; drugs; medications; biologicals; anesthesia and oxygen services; short-term physical, speech and occupational therapy; radiation therapy; inhalation therapy; chemotherapy; whole blood and blood products; and the administration of whole blood and blood products.

Inpatient Stay for Lymph Node Dissection or Lumpectomy: The Plan will cover Hospital inpatient services for Participants undergoing a lymph node dissection or lumpectomy. Coverage is available for the period determined to be Medically Necessary by you and your Physician.

Autologous Blood Banking Services: Autologous blood banking services are Covered only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, the Plan will cover storage fees for what The Plan determines to be a reasonable storage period that is Medically Necessary and appropriate for having the blood available when it is needed. Routine harvesting and storage of Stem Cells from newborn cord blood is not Covered.

Outpatient Services: The Plan Covers the inpatient Hospital services and supplies listed above that can be provided to you while being treated in the outpatient facility. Please remember, unless you are receiving preadmission testing, Network Hospitals are not

Network Providers for laboratory procedures and tests.

Please note: lab work and X-rays performed in a Hospital on an outpatient basis do not require Preauthorization.

X. Ambulatory Surgery Center

Coverage is available for Covered surgical procedures performed at Ambulatory Surgical Centers. The Plan also cover the Covered Services and supplies provided by the Center the day the surgery is performed.

Y. Skilled Nursing Facility

**This benefit requires Preauthorization and treatment plan.*

The Plan Covers non-custodial services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. In addition to Preauthorization, an admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by your Provider and approved by preauthorization vendor. The Plan Covers noncustodial care for the amount of days shown in your plan's Benefits Summary in the Appendix.

Please refer to your plan's Benefits Summary in the Appendix for any Limitations and Cost-Sharing requirements.

Z. Hospice

**This benefit requires Preauthorization for services rendered inpatient or in the home.*

Hospice Care is available to Participants who have a prognosis of six months or less to live. Coverage consists of palliative care rather than curative treatment. Hospice Care will be Covered only when provided as part of a Hospice Care program certified by the appropriately certified or licensed state hospice agency. Such certified programs may include Hospice Care delivered by: A Hospital (inpatient or outpatient), Home Health Care Agency, Skilled Nursing Facility or a licensed Hospice facility.

Coverage is not provided for: Bereavement Counseling, funeral arrangements, pastoral, financial or legal counseling; homemaker, caretaker or respite care.

Please refer to your plan's Benefits Summary in the Appendix for any Limitations and Cost-Sharing requirements.

MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES

Please refer to your plan's Benefits Summary in the Appendix for Cost-Sharing requirements, and any Preauthorization or Referral requirements that apply to these benefits.

Mental Health and Substance Abuse Facility must be JCAHO accredited.

Network Exceptions: If a JCAHO accredited Network Provider cannot perform or deliver the Covered Services

you need, you may receive Network coverage for Medically Necessary Covered Services from an Out-of- Network Provider. First, you must contact LEA Customer Service and Preauthorize the use of an Out-of-Network Provider.

Before Preauthorizing the use of an Out-of-Network Provider for Network Covered Services, the Plan may recommend another Network Provider who is able to render the services you need. However, if the Plan agrees that it is necessary for you to use an Out-of-Network Provider (and Preauthorizes the services), there will be no additional cost to you beyond your required Copayment.

Additionally, Preauthorization requests for admissions to Out-of- Network facilities (e.g., hospitals, rehabilitation centers) to be Covered on a Network basis will not be approved unless the Plan agrees that a Network Provider is unable to meet your specific medical needs. While you and your Network Provider may discuss having a procedure performed at a specific Out-of- Network facility, Network coverage is only available if the Plan agrees that the procedure cannot be safely performed at any Network facility. Any non-emergency Covered Services received at an Out-of-Network facility will be subject to the Out-of-Network level of benefits.

A. Autism Spectrum Disorders

The Plan Covers the diagnosis and treatment of Autism Spectrum Disorders (ASD) that are identified and ordered by a licensed physician, licensed psychologist or licensed clinical social worker for a Member who is diagnosed with ASD and that are provided in accordance with a treatment plan developed by a licensed physician, licensed psychologist or licensed clinical social worker pursuant to a comprehensive evaluation or re-evaluation of the Member. Coverage includes:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Behavioral Therapy.
- Direct psychiatric or consultative services provided by a licensed psychiatrist.
- Direct psychological or consultative services provided by a

licensed psychologist.

- Medication management.
- Prescription drugs when prescribed by a licensed physician, licensed physician assistant or advanced practice registered nurse for the treatment and symptoms and comorbidities of ASD. If the Plan has purchased "Outpatient Prescription Drug" coverage, some of these items may be Covered.
- Inpatient/24-hour supervisory care.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Services at a Residential Treatment Facility. Confinement in a Residential Treatment Facility must be based on an Individual Treatment Plan prescribed by the attending physician and approved by the Mental Health/Substance Use Disorder Designee. For this benefit, both of the following criteria must be met:
  - Residential Treatment Center Facility must be JCAHO accredited
  - The Member has a serious mental illness which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior as apparent by recent disturbed behavior.
  - The Member, upon assessment by a physician, psychiatrist, psychologist, or clinical social worker, cannot be effectively treated in an acute care, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment or outpatient setting.
  - Documented evidence from a licensed professional that:
    - Outpatient therapy with weekly sessions was not effective, and there is a likelihood of no improvement in current environment
    - Unsafe, declining behaviors; show symptoms and behaviors that represent a decline from usual state and include either self-injurious or risk-taking behavior that cannot be managed outside of 24-hour care.
    - Reasonable expectation that patient will improve in residential setting and be able to return to outpatient therapy for aftercare
- Individual, family, therapeutic group and provider-based case management services.
- Psychotherapy, consultation, and training session for parents and paraprofessional and resource support to family.
- Crisis intervention.
- Transitional care.

In addition, the following medical services are also Covered and will not accrue to any maximums or limitations reflected on the Summary of Benefits when rendered as part of a treatment plan for ASD:

- Physical therapy provided by a licensed physical therapist.
- Speech and language pathology services provided by a licensed speech and language pathologist.
- Occupational therapy provided by a licensed occupational therapist.

Also, if a Covered Person's primary diagnosis is autism, in addition to coverage for certain Therapy Services, as described above, the Plan also covers Medically Necessary and Appropriate: (a) Behavioral Interventions Based on Applied Behavioral Analysis (ABA); and (b) Related Structured Behavioral Programs. Such interventions and programs must be prescribed in a treatment plan.

B. Mental Health Services

Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital or an

Alternate Facility, and those received on an outpatient basis in a Physician's office or at an Alternate Facility.

Coverage for Mental Health Services includes:

- Mental health evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Inpatient stays.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Individual, family and group therapeutic services.
- Crisis intervention.
- Services at a Residential Treatment Facility. Confinement in a Residential Treatment Facility must be based on an Individual

Treatment Plan prescribed by the attending physician and approved by preauthorization vendor. For this benefit, the following criteria must be met:

- Residential Treatment Center Facility must be JCAHO accredited The Participant must have a serious mental illness which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior as apparent by recent disturbed behavior.
- The Participant, upon an assessment by a physician, psychiatrist, psychologist or clinical social worker cannot be effectively treated in an acute care, Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment or outpatient setting.
- Documented evidence from a licensed professional that:
  - Outpatient therapy with weekly sessions was not effective, and there is a likelihood of no improvement in current environment
  - Unsafe, declining behaviors; show symptoms and behaviors that represent a decline from usual state and include either self-injurious or risk-taking behavior that cannot be managed outside of 24-hour care.
  - Reasonable expectation that patient will improve in residential setting and be able to return to outpatient therapy for aftercare

Preauthorization vendor will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is Covered on a Semi-Private Room basis.

C. Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a Physician's office or at an Alternate Facility. Coverage for Substance Use Disorder Services includes:

- Substance Use Disorder and chemical dependency evaluations and assessment.
- Diagnosis.
- Treatment planning.
- Detoxification (sub-acute/non-medical).
- Inpatient stays.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Referral services.
- Medication management.
- Individual, family and group therapeutic services.
- Crisis intervention.
- Services at a Residential Treatment Facility. Confinement in a Residential Treatment Facility must be based on an Individual Treatment Plan prescribed by the attending physician and approved by preauthorization vendor. For this benefit, all of the following criteria must be met:
  - Residential Treatment Center Facility must be JCAHO accredited The Participant must have a serious mental illness which substantially impairs the person's thought, perception of reality, emotional process, or judgment or grossly impairs behavior.
  - The Participant, upon an assessment by a physician, psychiatrist, psychologist or clinical social worker cannot be effectively treated in an acute care, Partial Hospitalization/ Day Treatment, Intensive Outpatient Treatment or outpatient setting.
  - Documented evidence from a licensed professional that:
    - Outpatient therapy with weekly sessions was not effective, and there is a likelihood of no improvement in current environment
    - Unsafe, declining behaviors; show symptoms and behaviors that represent a decline from usual state and include either self-injurious or risk-taking behavior that cannot be managed outside of 24-hour care.
    - Reasonable expectation that patient will improve in residential setting and be able to return to outpatient therapy for aftercare

Preauthorization vendor will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is Covered on a Semi-Private Room basis.

Note: The plan does not provide coverage for Halfway Houses and Methadone Clinics.

EMERGENCIES

To obtain Coverage for Emergencies, you should follow the instructions below, regardless of whether or not you are in the Service Area at the time of the Emergency. Emergencies include Covered Services provided by any health care provider as outlined below:

The Plan defines an Emergency as follows: a serious medical condition or symptom resulting from Injury, Sickness or mental illness, or substance abuse disorders which: (a) arise suddenly; and (b) in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

With respect to a pregnant Participant who is having contractions, an emergency exists where: there is inadequate time to affect a safe transfer to another Hospital before delivery; or the transfer may pose a threat to the health or safety of the mother or the unborn child.

Emergencies include, but are not limited to, the following conditions:

- Severe chest pains
- Severe shortness of breath
- Severe or multiple injuries
- Loss of consciousness
- Convulsions
- Severe bleeding
- Poisonings
- Sudden change in mental status (e.g., disorientation)
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis

The Plan reserves the right to review all appropriate medical records and make the final decision regarding the existence of an Emergency. Regarding such retrospective reviews, the Plan will cover only those services and supplies that are Medically Necessary and are performed to treat or stabilize an Emergency condition.

A. Hospital Emergency Room Visits

In the event of an Emergency, seek immediate care at the nearest emergency room or call 911. Emergency room care is not subject to The Plan's prior approval. However, only Emergencies, as defined above, are Covered in an emergency room. If you would like assistance assessing the situation, you may call your Network Provider (if applicable).

Follow-up care provided in a Hospital emergency room is not Covered.

B. Emergency Hospital Admissions

In the event you are admitted to the Hospital, you or someone on your behalf must notify preauthorization vendor at the preauthorization vendor telephone number listed on the back of the member's identification card within 48 hours of your admission, or as soon as is reasonably possible.

It is important to remember that only those conditions that meet the requirements contained in the definition of Emergency will be Covered as an Emergency. Routine care received in an emergency room is not Covered.

C. Ambulance Services

**This benefit may require Preauthorization*

Ambulance services for life-threatening Emergencies will be Covered. Ambulance services for all other Emergencies will be Covered when Medically Necessary.

The Plan also covers pre-Hospital Emergency Medical Services. This means the Plan Covers the prompt evaluation and treatment of an Emergency in addition to non-air-borne transportation of the patient.

D. Urgent Care

The Plan defines Urgent Care as medical care for a condition that needs immediate attention to minimize severity and prevent complications but is not an Emergency.

If an Urgent Care visit results in an emergency admission, please follow the instructions for Emergency Hospital Admissions described above.

REIMBURSEMENT AND COPAYMENTS

When you receive Covered Services for an Emergency or Urgent Care situation from an Out-of-Network Provider who is not part of Anthem BCBS Network, the Plan will limit reimbursement to the Usual, Customary and Reasonable Charges for those expenses incurred up to the time the Participant is determined to be able to travel to a Network Provider. The Out-of-Network Reimbursement Amount is the amount charged or the amount the Plan determines to the reasonable charge, whichever is less, for a Covered Service in the geographical area it is performed. Additionally, reimbursement is subject to all applicable Copayments as similar services provided by a Network Provider.

GENDER AFFIRMING/REASSIGNMENT SURGERY

The treating physician or primary care provider must submit to Preauthorization vendor the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Preauthorization vendor will not be able to properly review the request for prior authorization. The clinical review criteria expressed below reflects how Preauthorization vendor determines whether certain services or supplies are medically necessary. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for, as some plans exclude coverage for services or supplies that considered medically necessary.

https://www.psychiatry.org/patients- families/gender-dysphoria/what-is-gender-dysphoria.

https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-01.htm#transgender.

https://www.wpath.org/publications/soc.

Definitions

Gender dysphoria - General descriptive term that refers to an individual's discontent with the assigned gender. It is more specifically defined when used as a diagnosis.

Transgender - Refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their gender at birth.

Transsexual - Refers to an individual who seeks, or has undergone, a social transition from male to female or female to male. In many, but not all, cases this also involves a physical transition through cross-sex hormone treatment and genital surgery (sex reassignment surgery).

Hormonal gender reassignment - The administration of androgens to genotypic and phenotypic females and estrogen or progesterones to genotypic or phenotypic males for the purpose of effecting somatic changes to more closely approximate the physical appearance of the genotypically other sex.

Hormones are also utilized for pubertal suppression.

Hormonal gender reassignment does not refer to the administration of hormones for the purpose of medical care or research conducted for the treatment or study of non–gender-dysphoric medical conditions (i.e., aplastic anemia, impotence, cancer).

Genital surgical gender reassignment - Genital surgery that alters the morphology to approximate the physical appearance of the genetically other sex. The surgical procedures in the table below (occurring in the absence of any diagnosable birth defect or other medically defined pathology [except gender dysphoria]) are included in this category.

Gender non-conforming (TGNC-Transgender/ Gender Non-Conforming) - Also referred to as non-binary. Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.

Non-binary - The individual's identity does not exist as a dichotomy of male or female (binary) but rather identifies as belonging to neither male nor female genders and prefer pronouns such as they and them, and possibly label themselves as Gender Non- Conforming.

Medically Necessary Procedures

Male-to-Female (MtF)	
• Breast augmentation	• Prostatectomy
• Clitoroplasty	• Urethroplasty
• Labioplasty	• Vaginoplasty
• Orchiectomy	• Vulvoplasty
• Penectomy	

Female-to-Male (FtM)	
• Breast reduction mammaplasty *(trial of hormone therapy not pre-requisite)*	• Oophorectomy Phalloplasty • Salpingectomy Scrotoplasty
• Hysterectomy	• Testicular/penile prosthesis implantation
• Mastectomy *(trial of hormone therapy not pre-requisite)*	• Urethroplasty • Vaginectomy
• Metoidioplasty	• Vulvectomy

Important:
Breast augmentation is considered medically necessary provided that the member has completed a minimum of 24 months of hormone therapy, during which time breast growth has been negligible; or hormone therapy is medically contraindicated; or the member is otherwise unable to take hormones. Genital electrolysis is not considered a surgical procedure, but is performed in conjunction with genital surgery (i.e., when required for vaginoplasty or phalloplasty)

Covered Services

A. Hormone therapy (whether or not in preparation for gender affirming/reassignment surgery) will be covered as follows:

1. Treatment with gonadotropin-releasing hormone agents (pubertal suppressants) when based upon a determination by a qualified medical professional that the member is eligible and ready for such treatment, i.e., that the member:
   a. Meets gender dysphoria diagnostic criteria
   b. Has experienced puberty to at least Tanner stage 2 with pubertal changes resulting in increased gender dysphoria
   c. Does not suffer from psychiatric comorbidity that interferes with diagnostic work-up or treatment
   d. Has adequate psychological and social support during treatment
   e. Demonstrates knowledge and understanding of expected treatment-outcomes associated with pubertal suppressants and cross-sex hormones, as well as the medical and social risks and benefits of sex reassignment
2. Treatment with cross-sex hormones, including testosterone, cypionate, conjugated estrogen, and estradiol, for members greater than or equal to 16 years of age, when based upon a determination of medical necessity made by a qualified medical professional. (Members less than 18 years of age must meet Criteria # 1).

Note: Requests for coverage of cross-sex hormones for members less than 16 years of age will be reviewed on a case-by-case basis.

B. Gender affirming/reassignment surgery will be covered for members greater than or equal to 18 years of age. The request must be accompanied by letters from two qualified licensed health professionals, acting within the scope of his/her practice, who have independently assessed the member and are referring the member for the surgery.

One letter must be from a psychiatrist, psychologist, psychiatric nurse practitioner (NP) or licensed clinical social worker (CSW) with whom the member has an established and ongoing relationship.

The other letter may be from a psychiatrist, psychologist, physician, psychiatric NP or licensed CSW who has only an evaluative role with the member.

Together, the letters must establish that the member:

1. Has a persistent and well-documented case of gender dysphoria
2. Has received hormone therapy (not prerequisite for mastectomy) appropriate to member's gender goals for a minimum of 12 months prior to seeking genital surgery (unless medically contraindicated or the member is otherwise unable to take hormones)
3. Has lived 12 months in gender role congruent with member's gender identity (inclusive of binary and Nonbinary Gender) and has received mental health counseling, as deemed medically necessary, during that time
4. Has no other significant medical or mental health conditions that would be a contraindication to gender reassignment surgery, or if so, that those are reasonably well- controlled prior to the gender reassignment surgery
5. Has the capacity to make fully informed decisions and consent to treatment

Limitations/Exclusions

A. Requests for gender reassignment surgery for members less than 18 years will be reviewed on a case-bycase basis.

B. The following services and procedures are excluded from coverage:
   1. Cryopreservation, storage, and thawing of reproductive tissue (including all related services and charges)
   2. Reversal of genital and/or breast surgery
   3. Reversal of surgery to revise secondary sex characteristics
   4. Reversal of any procedure resulting in sterilization

C. Coverage is not available for any surgeries, services or procedures that are purely cosmetic (i.e., when performed solely to enhance appearance, but not to medically treat the underlying gender dysphoria). The following surgery, services and procedures will be reviewed on a case by case basis. It is expected that the clinical rationale for each requested procedure is specifically documented in the letter of medical necessity from the treating physician. In addition, these types of requests need to be supported by articles in the peer reviewed literature:
   1. Abdominoplasty, blepharoplasty, neck tightening or removal of redundant skin
   2. Breast, brow, face or forehead lifts/augmentation, including removal of wrinkles (e.g., rhytidectomy)
   3. Calf, cheek, chin, nose or pectoral implants (e.g., genioplasty, mentoplasty, etc.)
   4. Collagen injections

5. Drugs to promote hair growth or loss
6. Electrolysis (unless required for vaginoplasty or phalloplasty)
7. Facial bone reconstruction, reduction or sculpturing (including jaw shortening) and rhinoplasty
8. Hair transplantation
9. Lip reduction
10. Liposuction
11. Osteoplasty
12. Thyroid chondroplasty
13. Voice therapy, voice lessons or voice modification surgery

BLUE CROSS BLUE SHIELD GLOBAL CORE PROGRAM - "GEOBLUE"

As a Blue Cross Blue Shield member, you take your health benefits with you when you travel outside the U.S. Through the Blue Cross Blue Shield Global Core Program also known as BlueCard Worldwide Program, you have access to doctors and hospitals around the world.

To take advantage of the program:

- Always carry your current member ID
- Before you travel, contact your Anthem BCBS company for coverage details. Coverage outside of the United States may be different.
- To locate a doctor or hospital call Service Center for Blue Cross Blue Shield Global Core call 1-800-810-2583 or collect at 1-804-673-1177

Benefits of utilizing the Blue Cross Blue Shield Global Core Service Center:

The online provider directory also includes non-contracted providers who are listed for referral purposes. Noncontracted providers can determine on a case-by-case basis if they'll accept a direct billing arrangement with AXA. The online provider directory also includes the "Preferred Provider" designation. A BCWW "Preferred Provider" is the best option locally in its category (hospital, primary care, etc.)

When you combine the following factors:

- level of medical care
- capacity to care for and interact with international patients (languages spoken, agrees to receive GOPs from abroad and send invoices)
- fair billing
- financial conditions – direct billing arrangement

Please note that a non-contracted provider may be designated by AXA as a "Preferred Provider" simply on the basis of being the only acceptable provider in the area to use (even if the provider does not accept direct billing arrangements)

Filing Blue Cross Blue Shield Global Core Claims:

- If the Blue Cross Blue Shield Global Core Service Center helped you get into a hospital, the hospital will file the claim for you. You will need to pay the hospital the Out-of-Pocket fees you normally pay.
- If the Blue Cross Blue Shield Global Core Service Center didn't help you get medical care, you will need to pay for provided services and send an international claim form with original itemized bills to the Service center.
- You may get international claim form by calling the customer services number on your ID card or online at www.bcbsglobalcore.com

Claims for services incurred on cruise ships cannot be processed through Blue Cross Blue Shield Global Core. These will need to be handled direct by the Fund office.

Note: If the member sees a professional healthcare provider or receives care in a hospital setting, the member may be responsible to pay up-front (subject to reimbursement)—regardless of the provider or hospital's participation status. The customer service representative will provide the member with the appropriate guidance.

SECTION 7: EXCLUSIONS AND LIMITATIONS

In addition to the exclusions and limitations set forth in the various benefit sections of this SPD, the following circumstances may cause loss of benefits and/or charges and expenses which are not payable from the Plan. Benefits are denied when it is determined that, at the time the claim was Incurred, you or your Dependent, as the case may be:

i. Was not eligible for benefits claimed.

ii. Failed to submit required evidence to substantiate the claim.

iii. Failed to apply or make timely application for benefits.

iv. Made intentional material misstatements in connection with eligibility or any payments made in reliance on such misstatement.

v. Omitted facts or material statements as to other insurance available to you and your Dependents

Each benefit section of this SPD may contain limitations and exclusions that apply to that particular benefit. The following exclusions and limitations apply to all benefits under the Plan except as otherwise specifically indicated in Employee Benefit Summaries in the appendices A to O.

Benefits under the Plan do not include coverage for:

1. Services which are not Medically Necessary. If there is a dispute between a Provider and the Plan about the Medical Necessity of a service or supply, you or your designated representative may appeal the Plan's decision. Any disputed service or supply will not be Covered during the appeal process.
2. Acupuncture therapy.
3. An adopted newly born infant's initial hospital stays if the natural parent has coverage available for the infant's care.
4. Blood, blood plasma and blood derivatives other than those described as Covered Services. Synthetic blood, apheresis or plasmapheresis, the collection and storage of blood, and the cost of securing the services of blood donors are not Covered.
5. Care for conditions that by federal, state or local law must be treated in a public facility including, but not limited to, commitments for mental illness. Additionally, to the extent allowed by law, the Plan does not Cover care or treatment provided in an Out-of-Network Hospital that is owned or operated by any federal, state or other governmental entity, unless otherwise required by law.
6. Comfort or convenience items including, but not limited to: barber services; guest meals and accommodations; telephone, television or radio charges; travel expenses; or take-home supplies. The Plan also does not Cover the purchase or rental of household fixtures or equipment including, but not limited to: escalators; elevators; swimming pools; exercise cycles; treadmills, weight training or muscle strengthening equipment; air purifiers; air conditioners; water purifiers; allergenic pillows, mattresses or waterbeds.
7. Cosmetic, reconstructive or plastic surgery that is done for a condition that does not meet the specific criteria stated in "Reconstructive and Corrective Surgery," including but not limited to: cosmetic surgery, plastic or reconstructive surgery which is performed primarily to improve the appearance of any portion of the body including but not limited to: surgery for sagging or extra skin; any augmentation or reduction procedure (e.g., mammoplasty); liposuction; rhinoplasty and rhinoplasty done in conjunction with Covered nasal or Covered sinus surgery. Complications of such surgeries are Covered only if they are Medically Necessary and are otherwise Covered. Remedial work is not Covered.
8. Court ordered services or services that have been ordered as a condition of probation or parole. However, these services may be Covered if the Plan agrees that the services are Medically Necessary, are otherwise Covered, the Participant has not exhausted their benefit for the Plan Year, and the treatment is provided in accordance with our policies and procedures.
9. Custodial care, domiciliary care, long-term care, maintenance care, adult day care or rest cures. The Plan does not Cover room, board, nursing care or personal care which is rendered to assist a Participant who, in the Plan's opinion, has reached the maximum level of physical or mental function possible and will not make further significant clinical improvement.
10. Services in connection with elective cosmetic surgery. The Plan does not cover cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such services is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent which has resulted in a functional defect.

11. Dental services related to the care, filling, removal or replacement of teeth and the treatment of injuries or diseases of the teeth, gums and temporomandibular joint, including, but not limited to: apicoectomy, orthodontics, root canals, soft tissue impaction, temporomandibular joint dysfunction therapy, alveolectomy, and treatment of periodontal disease or orthognathic surgery. As described in "Oral Surgery," only dental services required to treat accidental injury of sound, natural teeth are Covered.

12. The following are not Covered as diabetic services or supplies: services or supplies that are not both Medically Necessary and prescribed by the Participant's Physician or qualified health professional; membership in health clubs, diet plans or clubs even if recommended by a Physician or any other provider for purpose of losing weight; any counseling or courses in diabetes management other than as described as Covered under this SPD; stays at special facilities or spas for the purpose of diabetes education/ management; special foods, diet aids and supplements related to dieting.

13. Durable Medical Equipment (other than as specifically Covered under this SPD). The Plan also does not Cover: TENS units (except as Covered under Durable Medical Equipment); blood pressure monitoring devices; car seats; arch supports; cervical collars; corrective shoes; false teeth; tilt tables; electronic communication devices; in-flight oxygen for non-emergency travel; special supplies or equipment; or special appliances.

14. Experimental, investigational or ineffective surgical or medical treatments, procedures, drugs, or research studies including, but not limited to: transplants, stem cell retrieval, cancer chemotherapy protocols, AIDS clinical trials or I.V. therapies that are not recognized as acceptable medical practice and any such services where federal or other governmental agency approval is required but has not been granted. Preauthorization vendor will make the determination as to whether the requested service is excluded in accordance with this provision. In certain instances, such procedures may be Covered if they are approved in advance by preauthorization vendor's Medical Advisory Board and provided in accordance with the provisions of this SPD. Under no circumstances will the Plan Cover autologous bone marrow transplants combined with high dose chemotherapy except, when medically appropriate, for the treatment of: advanced neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, and metastatic breast cancer or any other diagnosis that preauthorization vendor's Medical Advisory Board determines to be appropriate. Such treatment must be approved in advance by preauthorization vendor's Medical Advisory Board and provided in accordance with the provisions of this SPD. The Plan does not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, the Plan will cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when the Plan's denial of services is overturned by an External Appeal Agent. However, for clinical trials the Plan will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the SPD for non-investigational treatments. The Plan will cover routine patient costs associated with a clinical trial, as specified in this SPD.

15. Improper use of an emergency room or emergency admissions. Care and treatment for conditions that the Plan determines were not Emergencies, when received in an emergency room, are not Covered.

16. Infertility treatments and supplies (except as otherwise Covered under this SPD), even if the treatment or supply is for a purpose other than the correction of infertility. The following services and supplies are not Covered: cost for an ovum donor or donor sperm, sperm storage costs, chromosomal analyses, testicular biopsy, elective abdominal surgeries related to lysis of adhesions or asymptomatic varicoceles, radiographic imaging to determine tubal patency; blood analyses related to immunological diagnosis of infertility, cryopreservation and storage of embryos (unless the Participant has not yet reached her lifetime limit of four egg retrievals), in-vitro services for women who have undergone tubal ligation, any infertility services if the male has undergone a vasectomy and all costs for and relating to surrogate motherhood (maternity services are Covered for Participants acting as surrogate mothers). The Plan also does not Cover services to reverse voluntary sterilization. Treatment of an underlying medical condition will not be denied (if the treatment is otherwise covered under the SPD) solely because the medical condition results in infertility.

17. Learning and behavioral disorders. Services for the evaluation or treatment (including remedial education) of: learning disabilities or minimal brain dysfunction;

Intellectual Disability; developmental and learning disorders or behavioral problems. The Plan also does not Cover behavioral training, visual perceptual or visual motor training related to learning disabilities or cognitive rehabilitation. Behavioral and learning disorders related to congenital abnormalities such as Down's Syndrome are not Covered.

18. Services and treatment provided in a government facility, i.e., military services-related injuries, unless otherwise required by law.
19. No-fault automobile insurance. Any Covered Services that are payable as personal injury benefits under mandatory no-fault automobile insurance.
20. Non-eligible institutions. Any services or supplies furnished by a non-eligible institution, which is defined as other than a Hospital or Skilled Nursing Facility, and which is primarily a place of rest, a place for the aged, or any similar institution, regardless of how denominated.
21. Non-medical services and long-term rehabilitation services for physical therapy or the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility, except as specifically Covered under this SPD.
22. No-show charges. If a Provider charges a fee for a missed appointment, you will be responsible for the payment of the fee.
23. Occupational conditions, ailments, or injuries arising out of and in the course of employment. Such conditions, ailments or injuries are not Covered if they are subject to coverage, in whole or in part, under any workers' compensation, occupational disease or similar law. This applies even if the Participant's rights have been waived or qualified.
24. Outpatient Prescription Drugs.
25. Private or special duty nursing.
26. Rehabilitation services or physical therapy on a long-term basis. Speech or occupational therapy to correct a condition that is not the result of a disease, injury or a congenital defect for which surgery has been performed.
27. Topical hyperbaric oxygen chamber, disposable.
28. Routine foot care including nail trimming, corn and callous removal, cleaning, soaking or any other hygienic maintenance or care.
29. Services for which the day or visit limit identified in your plan's Benefits Summary in the Appendix has been met.
30. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
31. Sex, marital or religious counseling, including sex therapy and treatment of sexual dysfunction.
32. Special foods and diets, supplements, vitamins and enteral feedings, except as what is otherwise outlined in this SPD. When coverage of special foods, diets and enteral feedings are available, it is subject to periodic review for Medical Necessity. Infant formulas are not Covered.
33. Special medical reports not directly related to treatment. Appearances in court or at a hearing.
34. Third party requests for physical examinations, diagnostic services and immunizations in connection with: obtaining or continuing employment; obtaining or maintaining any license issued by a municipality, state or federal government; obtaining insurance coverage; foreign travel; school admissions or attendance including examinations required for participation in athletic activities. Court ordered psychological or behavioral evaluations or counseling related to marital disputes, divorce proceedings, or child custody proceedings are not Covered.
35. Transplant services required by a Participant when the Participant serves as an organ donor are not Covered unless the recipient is a Participant. The medical expenses of a non-Participant acting as a donor for a Participant are not Covered if the non-Participant's expenses will be covered under another health plan or program. Donor fees in connection with organ transplant surgery are excluded. The Plan does not Cover travel expenses, lodging, meals or other accommodations for donors or guests. Transplants performed in facilities other than those designated by preauthorization vendor for the transplant procedure are not Covered.
36. Treatment provided in connection with services for individuals who are presently incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the office of children and family services.
37. Coverage outside of the United States, unless benefits are utilized by the Blue Cross Blue Shield Global Core Service Center and are received within the BlueCard program.
38. Unnecessary Care. In general, the Plan will not Cover

any health care service that in the Plan's sole judgment, determines is not Medically Necessary. If an External Appeal Agent overturns the Plan's denial, however, the Plan shall cover the procedure, treatment, service, pharmaceutical product, or durable medical equipment for which coverage has been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise Covered under the terms of this SPD.

39. Care, supplies, treatment, and/or services that exceed(s) Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge. This shall include charges that are more than the Usual and Customary amount or are for services not deemed to be Reasonable or Medically Necessary, in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

40. Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury);

41. Wigs, or any other appliance or procedure related to hair loss regardless of the disease or injury causing the hair loss (except following chemotherapy).

42. Weight Control. All services, supplies, programs and surgical procedures for weight control.

43. Any service, supply or treatment not specifically listed in this SPD as a Covered Service, supply or treatment. Any supply or treatment for which the Participant has no legal obligation to reimburse the Provider. Any supply or treatment provided by a Participant or the Participant's family (mother, stepmother, father, stepfather, sister, step-sister, brother, step-brother, any "in- law," aunt, uncle, niece, nephew or cousin).

44. Administrative Costs. Care, supplies, treatment, and/or services that are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

45. After the Termination Date. Care, supplies, treatment, and/or services that are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

46. Alcohol. Care, supplies, treatment, and/or services that arise from a Participant taking part in any activity made illegal due to the use of alcohol or a state of intoxication, even if the cause of the illness or Injury is not related to the use of alcohol. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

47. Illegal Acts. Care, supplies, treatment, and/or services that are for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies, even if the cause of the illness or Injury is not related to the commission of the illegal act. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

48. Immediate Family Member. Care, supplies, treatment, and/or services that are rendered by a member of the immediate Family Unit or person regularly residing in the same household, whether the relationship is by blood or exists in law.

49. Incurred by Other Persons. Care, supplies, treatment, and/or services that are expenses Incurred by other persons.

50. Negligence. Care, supplies, treatment, and/or services that are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, considering applicable laws and evidence available to the Plan Administrator.

51. No Coverage. Care, supplies, treatment, and/or services that are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent.

52. No Legal Obligation. Care, supplies, treatment, and/or

services that are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.

53. Not Acceptable. Care, supplies, treatment, and/or services that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

54. Other than Attending Physician. Care, supplies, treatment, and/or services that are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease and performed by an appropriate Provider.

55. Prior to Coverage. Care, supplies, treatment, and/or services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

56. Provider Error. Care, supplies, treatment, and/or services that are required because of unreasonable Provider error.

57. Self-Inflicted. Care, supplies, treatment, and/or services that are Incurred due to an intentionally selfinflicted Injury or illness, not definitively (a) resulting from being the victim of an act of domestic violence, or (b) resulting from a documented medical condition (including both physical and mental health conditions).

58. Subrogation, Reimbursement, and/or Third-Party Responsibility. Care, supplies, treatment, and/or services that are for an illness, Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.

59. Unreasonable. Care, supplies, treatment, and/or services that are not "Reasonable" and are required to treat illness or Injuries arising from and due to a Provider's error, wherein such illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(s).

60. War/Riot. Care, supplies, treatment, and/or services that Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This exclusion does not apply to any Participant who is not a member of the armed forces and does not apply to victims of any act of war or aggression.

The Plan does not limit your right to choose your own medical care. If a medical expense is not covered under the Plan, or is subject to a limitation or exclusion, you still have the right and privilege to receive such medical service or supply at your own personal expense.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide benefits other than those provided under the terms of the Plan.

SECTION 8: PARTICIPANT RIGHTS AND RESPONSIBILITIES

WHAT ARE MY RIGHTS AS A PARTICIPANT?

As a Participant you have the following rights:

1. The right to obtain complete and current information concerning a diagnosis, treatment and prognosis from any Network Provider in terms that you or your authorized representative can readily understand. You have the right to be given the name, professional status and function of any personnel delivering Covered Services to you.

   You have the right to receive all information from a Network Provider necessary for you to give your informed consent prior to the start of any procedure or treatment.

   You also have the right to refuse treatment to the extent permitted by law. The Plan and your PCP will make every effort to arrange a professionally acceptable alternative treatment. However, if you still refuse the recommended treatment and the Plan and your Network Provider believe no professionally acceptable alternative exists, the Plan will not be responsible for the cost of further treatment for that condition. You will be notified accordingly.

   If a Participant is not capable of understanding any of this information, an explanation will be provided to his or her guardian, designee or a family Participant.

2. The right to be provided with information about the Plan's services, policies, procedures, grievance and appeal procedures and Anthem BCBS Network Providers that accurately provides relevant information in a manner that is easily understood.

3. The right to quality health care services provided in a professional manner that respects your dignity and protects your privacy. You also have the right to participate in decision-making regarding your health care.

4. The right to privacy and confidentiality of your health records, except as otherwise provided by law or contract. You have the right to all information contained in your medical records unless access is specifically restricted by the attending physician for medical reasons.

5. The right to initiate disenrollment from the Plan.

6. The right to file an appeal of a denied claim.

7. The right, when Medically Necessary, to emergency care without unnecessary delay.

8. The right to be advised if any of the Network Providers participating in your care propose to engage in or perform human experimentation or research affecting your care or treatment. You or a legally responsible party on your behalf may, at any time, refuse to participate in or to continue in any experimentation or research program to which you have previously given informed consent.

9. The right to sign-language interpreter services in accordance with applicable laws and regulations when such services are necessary to enable you as a person with special communication needs to communicate effectively with your provider.

WHAT ARE MY RESPONSIBILITIES?

Your Responsibilities Include:

1. To enter into this Plan with the intent of following the policies and procedures as outlined in this SPD.

2. To take an active role in your health care through maintaining good relations with your Provider and following prescribed treatments and guidelines.

3. To provide, to the extent possible, information that professional staff need to care for you as a Participant.

4. To use the emergency room only as described in this SPD.

5. To notify the proper Plan representative of any change in name, address or any other important information.

SECTION 9: CLAIMS PROCEDURES

WHAT THIS SECTION INCLUDES:

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

NETWORK BENEFITS

In general, if you receive Covered Services from a Network provider, the Plan will pay the Physician or facility directly. If a Network provider bills you for any Covered Service other than your Copay or Coinsurance, please contact the provider or call the Customer Service phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

If you receive Covered Services from a Network Provider but not in accordance with the terms and conditions of this SPD, coverage will be provided as described in this SPD. When you see a Network Provider under these circumstances, the Covered Services will be treated as if they were delivered by an Out-of-Network Provider, and you must file a claim as described below.

OUT-OF-NETWORK BENEFITS

If you receive a bill for Covered Services from an Out-of-Network provider, you (or the provider if they prefer) must send the bill to Anthem BCBS for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to Local Anthem BCBS Blue Card address.

HOW TO SUBMIT A CLAIM

You can obtain a claim form by calling the toll-free Leading-Edge Customer Service number on your ID card or contacting your Plan Administrator. If you do not have a claim form, simply attach a brief letter of explanation to the bill and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Participant;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and
  - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you. The above information should be filed with Local Anthem BCBS Blue Card address.

PAYMENT OPTIONS

When you receive Covered Services from an Out-of-Network Provider, the Plan will reimburse you in the amount of the out-of-network benefit, if applicable, and you will then be responsible for reimbursing the Provider. You may not assign the right to reimbursement under this SPD to an Out-of-Network Provider without the Plan's consent. However, in the Plan's discretion, the Plan may pay an Out-of-Network Provider directly.

LIMITATIONS

All requests for reimbursement must be made within 90 days of the date Covered Services were rendered. Failure to request reimbursement within the required time will not invalidate or reduce any claim if it was not reasonably possible to provide such proof within the 90-day period. However, such request must be made as soon as reasonably possible thereafter. Under no circumstances will the Plan be liable for a claim that is submitted more than six months after the date services were rendered, unless you are legally incapacitated and unable to submit the request. All reimbursements to Out-of-Network Providers are subject to an Out-of-Network Reimbursement Amount.

IF YOU RECEIVE A BILL FROM A NETWORK PROVIDER

The cost of Covered Services provided by Network Providers in accordance with the terms of this SPD will be billed directly to Anthem BCBS. **No claim forms are necessary.**

If you should receive a bill from a Network Provider for Covered Services, please contact the LEA Customer Service Department immediately.

CLAIM INFORMATION

Please allow up to 30 business days for the processing of Network claims. Claims for Out-of- Network Covered Services will be paid within 60 business days after the Plan receives proof of the claim.

If necessary, LEA's Claims Department will contact you for more information regarding your claim to speed up the processing. If you would like to inquire about the status of a claim, call the "Claims" telephone number list in the front of this SPD. Please have the date of service and your ID number ready.

EXPLANATION OF BENEFITS (EOB)

You may request that LEA send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the LEA toll-free Customer Service number on your ID card to request them. You can also view and print all of your EOBs.uwf-portal@leadingedgeadmin.com

LIMITATION OF ACTION

You cannot bring any legal action against the United Welfare Fund, the Plan Administrator or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the United Welfare Fund, the Plan Administrator or the Claims Administrator you must do so within one year of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

CLAIM DENIALS AND APPEALS

Employee Retirement Income Security Act (ERISA) Rights:

After all levels of Appeals have been completed, the Participant may have the right to file a civil action under 502(a) of the Employee Retirement Income Security Act. ERISA rights do not apply if the Participant's coverage for health benefits was:

1. Obtained through employment with a church or government group; or
2. Purchased as an individual plan from any carrier.

APPEALS PROCESS

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the SPD upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
4. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review.
6. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.
7. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request).
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or

Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.

10. In a claim involving urgent care, a description of the Plan's expedited review process.

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. At least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
5. A review that considers all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
7. The identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
8. That a Claimant will be provided, free of charge: (a) upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Claims Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.
9. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

Requirements for Appeal

The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within at least 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-Service urgent care claims, if the Claimant chooses to initiate an appeal orally, the Claimant may telephone:

Leading Edge Administrators (LEA)
14 Wall Street, Suite 5B
New York, NY 10005
1-877-797-2776

Oral appeals should be submitted in writing as soon as possible after it has been initiated.

To file any appeal in writing, the Claimant's appeal must be addressed as follows:

1. For Pre-service Claims:
   Claimants should refer to their identification card for the name and address of the utilization review administrator. All Pre-service claims must be sent to the utilization review administrator.
2. For Post-Service Claims:

Leading Edge Administrators (LEA)
14 Wall Street, Suite 5B
New York, NY 10005
1-877-797-2776

It shall be the responsibility of the Claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the employee/Claimant.
2. The employee/Claimant's social security number.
3. The group name or identification number.
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant fails to include them in the appeal.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

1. **Pre-service Urgent Care Claims:** As soon as possible, considering the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. **Pre-service Non-Urgent Care Claims:** Within a reasonable timeframe appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
3. **Concurrent Claims:** The response will be made in the appropriate timeframe based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. **Post-service Claims:** Within a reasonable timeframe, but not later than 60 days after receipt of the appeal.
   NOTE: This timeframe is reduced to no later than 30 days per internal appeal should the Plan allow for two levels of internal appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Claimant with notification, with respect to Pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
3. A reference to the specific portion(s) of the plan provisions upon which a denial is based.
4. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an

appeal.

9. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request.
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the provision relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

DECISION ON REVIEW

The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. The Plan Administrator has the complete discretion to interpret the terms in this SPD, in the Plan, and in all governing documents of the Fund and to make all decisions concerning benefits available under the Plan. Further, any decisions or interpretations made by the Plan Administrator shall not be overturned unless found to be arbitrary and capricious by a Court of Law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer.
2. A rescission of coverage (whether the rescission has any effect on any particular benefit at that time).

Standard External Review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. **Request for external review.** The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. **Preliminary review.** Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.
   b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or

similar determination).

c. The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the interim final regulations.

d. The Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review with the four month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization.** The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will act against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Administrator to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. **Request for expedited external review.** The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:

   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal.

   b. A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.

3. **Referral to Independent** Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. **Notice of final external review decision.** The Plan's (or Claims Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external

review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

DEEMED EXHAUSTION OF INTERNAL CLAIMS PROCEDURES AND DE MINIMIS

Exception to the Deemed Exhaustion Rule

A Claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Claimant may proceed immediately to the External Review Program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Claimant must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant, and the violation is not reflective of a pattern or practice of non- compliance. If a Claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

PAYMENT OF BENEFITS

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an Assignment of Benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, 62 | P a g e agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the Institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an Assignment of Benefits occurred.

Assignments

Coverage and your rights under this Plan may NOT be assigned. A direction to pay a provider or an assignment of the right to receive payment for provision of a benefit is NOT an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding or of any legal or equitable right under any law of the United States or any, individual State.

Non-U.S. Providers

See Blue Cross Blue Shield Global Core Program - "GeoBlue" in the Section 6, page 45

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits

payable (including payment of future benefits for other Injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error.
2. Pursuant to a misstatement a fraudulent act, or the omission of a material fact
3. Pursuant to a misstatement made to obtain coverage under this Plan.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third-Party Recovery, Subrogation and Reimbursement provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment of payment for benefits from the Plan, abstain from billing the Claimant for any outstanding amount(s).

SECTION 10: COORDINATION OF BENEFITS

WHAT THIS SECTION INCLUDES:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the followings:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit, other than Medicaid to which this Plan is always primary

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Please note: This Plan does not coordinate benefits with itself.

EXCESS INSURANCE

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

- Any primary payer besides the Plan.
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
- Any policy of insurance from any insurance company or guarantor of a third party.
- Workers' compensation or other liability insurance company.
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
  - the parents are married or living together whether they have ever been married and not legally separated; or
  - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the spouse of the parent with custody of the child; then

- the parent not having custody of the child; then
- the spouse of the parent not having custody of the child;

- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

1. Let's say you and your spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
2. Again, let's say you and your spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary it determines the amount it will pay for a Covered Service by following the steps below.

- the Plan determines the amount it would have paid based on the allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference up to the amount of the allowable expense.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary, the allowable expense is the primary plan's Network rate, provided that the primary plan's network rate is reasonable and customary. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and an Out-of-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is an Out-of-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is an Out-of-Network provider for both the primary plan and this Plan, the allowable expense is the lesser of the two Plans' reasonable and customary charges.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

WHEN A PARTICIPANT QUALIFIES FOR MEDICARE

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare.

There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older;
- individuals with end-stage renal disease, for a limited timeframe.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, if the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may get the facts needed from, or give them to, other organizations or persons for applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The Plan does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan any facts needed to apply those rules and determine benefits payable. If you do not provide the Plan the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, United Welfare Fund may recover the amount in the form of salary, wages, or benefits payable under any plans related to the United Welfare Fund, including this Plan. The Plan also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, LEA on behalf of the Plan reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If United Welfare Fund pays for Benefits for expenses incurred because of a Participant, that Participant, or any other person or organization that was paid, must make a refund to United Welfare Fund if:

- all or some of the expenses were not paid by the Participant or did not legally have to be paid by the Participant;
- all or some of the payment United Welfare Fund made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The refund equals the amount United Welfare Fund paid more than the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Participant agrees to help United Welfare Fund get the refund when requested. If the Participant, or any other person or organization that was paid, does not promptly refund the full amount,

United Welfare Fund may reduce the amount of any future Benefits for the Participant that are payable under the Plan. The reductions will equal the amount of the required refund. United Welfare Fund retains all other rights to seek relief in addition to the right to reduce future Benefits.

SECTION 11: SUBROGATION AND REIMBURSEMENT

This section includes, how your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as defined below.

RIGHT OF RECOVERY

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- due to a misstatement, a fraudulent act, or the omission of a material fact;
- advanced during the time of meeting the Deductible; or
- advanced during the time of meeting the Out-of-Pocket Maximum for the calendar year. Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.
- If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:
- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.
- The Plan has the right to recover Benefits it has advanced by:
- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

RIGHT TO SUBROGATION

The right to subrogation means the Plan is substituted to and shall succeed to all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

RIGHT TO REIMBURSEMENT

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

THIRD PARTIES

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- United Welfare Fund in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third-party administrator.

SUBROGATION AND REIMBURSEMENT PROVISIONS

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident,

and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage"). Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third-party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for all expenses (fees and costs) associated with the Plan's attempt to recover such money. If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant must notify the Plan or its authorized representative of any written demand and/or lawsuit that he or she has made or filed that relate to any claim the Participant may have for payment for Injury, Sickness, Disease or disability for which the Plan paid benefits or may be obligated for the payment of benefits within 30 days of such demand or commencement of lawsuit. In addition, the Participant must notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant and his or her attorney are also obligated to hold all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

- The responsible party, its insurer, or any other source on behalf of that party.
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
- Any policy of insurance from any insurance company or guarantor of a third party.
- Workers' compensation or other liability insurance company.
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall

have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant and his or her attorney are deemed held in constructive trust and should not be dissipated or disbursed until the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant and his or her attorney are also obligated to hold all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected because of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s). This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan because of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

- Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
- Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
- In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
- Hold all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.
- Direct his or her attorney to hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

- The responsible party, its insurer, or any other source on behalf of that party.
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage,

uninsured or underinsured motorist coverage.

- Any policy of insurance from any insurance company or guarantor of a third party.
- Workers' compensation or other liability insurance company.
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s) or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

If the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by

the Plan:

- To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
- To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
- To take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights.
- To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
- To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
- To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
- To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
- To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
- In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
- To make good faith efforts to prevent disbursement of settlement funds until any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, because of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or courtappointed guardian shall cooperate in all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as

these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

If any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

SECTION 12: WHEN COVERAGE ENDS

This section includes Circumstances that cause coverage to end, and how to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the first of the month following the month in which you were last employed by a Participating Employer or on the first of the month in which no contributions have been made on your behalf, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, United Welfare Fund will still pay claims for Covered Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. When a Participant loses eligibility, his or her Dependents will also become ineligible on that date.

Your coverage under the Plan will end on the earliest of:

- the first of the month following the month in which you were last employed by a Participating Employer; the date the Plan ends;
- the first of the month in which no contributions have been made on your behalf;
- the first of the month following the month in which you are no longer an eligible employee;
- the last day of the month the Claims Administrator receives written notice from United Welfare Fund to end your coverage, or the date requested in the notice, if later;
- the last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage; or
- the date your employer ceases to be a participating employer.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the first of the month in which no contributions have been made on your behalf
- the date the Claims Administrator receives written notice from United Welfare Fund to end your coverage, or the date requested in the notice, if later;
- the last day of the month your Dependents no longer qualify as Dependents under this Plan, until the end of the calendar month in which he/she attains age 26.

Note: Occasionally, Participating Employers refuse to honor their collective bargaining agreement obligation to make contributions on behalf of Eligible Employees. Whenever that occurs, the Union and/or Fund will demand that the delinquent employer cure his or her default. If the employer persists in his or her default, then the Board of Trustees, acting under the Trust Agreements governing this plan and collective bargaining agreements, may immediately terminate coverage for that employer's employees. Should that occur, you will be sent written notice to that effect. Pursuant to the collective bargaining agreement, your employer may be directly responsible for compensating you for any loss. You may not be eligible to receive any benefits for such period of time where timely and full contributions have not been made.

OTHER EVENTS ENDING YOUR COVERAGE

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to you or another person's eligibility or status as a Dependent; or
- you commit an act of physical or verbal abuse that imposes a threat to United Welfare Fund 's staff, LEA's staff, a provider or another Participant.

Note: United Welfare Fund has the right to demand that you pay back Benefits the Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

COVERAGE FOR A DISABLED CHILD

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, if:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to United Welfare Fund proof of the child's incapacity and dependency within 31 days of the date coverage

would have otherwise ended because the child reached a certain age; and

- you provide proof, upon United Welfare Fund's request, that the child continues to meet these conditions.

The proof might include medical examinations at United Welfare Fund's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, if the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

CONTINUING COVERAGE THROUGH COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in the *Glossary.*

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if United Welfare Fund is subject to the provisions of COBRA.

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

To be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- a Participant;
- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

QUALIFYING EVENTS FOR CONTINUATION COVERAGE UNDER COBRA

Table 1 on the following page outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

HOW YOUR MEDICARE ELIGIBILITY AFFECTS DEPENDENT COBRA COVERAGE

Table 2 on the following page outlines outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

GETTING STARTED

You will be notified by mail if you become eligible for COBRA coverage because of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage and advise you of the monthly cost. Your monthly cost is the full cost of the Plan, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment Period; and
- following a change in family status, as described under Changing Your Coverage.

NOTIFICATION REQUIREMENTS

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

Table 1: Qualifying Events for Continuation Coverage Under COBRA

If Coverage Ends Because of the Following Qualifying Events	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	n/a	36 months	36 months
You divorce (or legally separate)	n/a	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	n/a	n/a	36 months
You become entitled to Medicare	n/a	See Table 2	See Table 2
United Welfare Fund files for bankruptcy under Title 11, United States Code[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Participant's death if the Participant dies during the continuation coverage.

Table 2: How Your Medicare Eligibility Affects Dependent COBRA Coverage

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage for Up
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

*Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60-day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

NOTIFICATION REQUIREMENTS FOR DISABILITY DETERMINATION

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Benefits Department with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Important Administrative Information: ERISA section. The contents of the notice must be such that the Plan Administrator is able to determine the covered employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

TRADE ACT OF 2002 AND TRADE PREFERENCES ACT OF 2015

The Trade Preferences Extension Act of 2015 has extended certain provisions of the Trade Reform Act of 2002, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a Health Coverage Tax Credit (HCTC) or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

A Participant's eligibility for subsidies under the Trade Preferences Extension Act of 2015 affects his or her eligibility for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, a Participant must choose one or the other, and if he or she receives both during a tax year, the IRS will reconcile his or her eligibility for each subsidy through his or her individual tax return. Participants may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

Participants may contact the Plan Administrator for additional information or they have any questions they may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Reform Act is available at www.doleta.gov/tradeact; for information about the Health Coverage Tax Credit (HCTC), please see: https://www.irs.gov/Credits-&-Deductions/Individuals/HCTC.

WHEN COBRA ENDS

COBRA coverage will end before the maximum continuation period shown above if:

- after electing COBRA, you or your covered Dependent becomes covered under another group medical plan;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the 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 in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- the 24-month period beginning on the date of the Participant's absence from work; or
- the day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

OTHER AVAILABLE COVERAGE

Leave of Absence or Layoff

If your coverage would terminate because you are temporarily laid off or receive an approved leave of absence under the applicable collective bargaining agreement, coverage may be continued for up to 60 days, or as otherwise agreed upon by the Plan Administrator, if a participating employer pays the benefit cost contributions for the continued coverage, unless otherwise required by law or the SPD.

Family and Medical Leave Act (FMLA)

Federal law provides that certain employees can take up to 12 weeks of unpaid leave in a 12-month period for:

- the birth or adoption of a child;
- for a serious health condition affecting the employee or the employee's spouse, child or parent;
- for any qualifying exigency arising out of the fact that the employee's spouse, child or parent is on or has been called to active duty in the Armed Forces; or
- up to 26 weeks of unpaid leave in a 12-month period to care for an injured service member. Employers subject to this law are required to keep an employee's medical coverage in force to the same extent as if no leave had been taken. Your obligations, including any contributions and compliance with Plan provisions, do not change during a leave.

If your employer is subject to this law, and you are eligible for leave under the Act, the Plan will continue your coverage during the qualified leave. Coverage will terminate for failure to comply with Plan provisions, including the failure to pay benefit cost contributions. You should check with your employer regarding family and medical leaves.

SECTION 13: OTHER IMPORTANT INFORMATION

This section includes:

- Qualified Medical Child Support Orders;
- The Genetic Information Nondiscrimination Act;
- Section 1557 Compliance;
- Model Newborn Act's Disclosure;
- Women's Health and Cancer Rights Act Notice
- Your relationship with LEA and United Welfare Fund;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers;
- The future of the Plan; and
- How to access the official Plan documents.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") and ERISA prohibit group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information. Accordingly, the Plan does not discriminate on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

i. An individual's genetic tests;

ii. The genetic tests of family members of an individual; and

iii. An individual's family members' manifested diseases or disorders.

A genetic test is an analysis of human chromosomes, DNA, RNA or proteins that detects genotypes, mutations, or chromosomal changes.

For example, a genetic test includes a test to determine whether someone has the BRCA1 or BRAC2 variant indicating a predisposition to breast cancer, a test to determine whether someone has a genetic variant associated with hereditary nonpolyposis colon cancer and a test for a genetic variant for Huntington's disease.

The Plan will not require that a Participant undergo a genetic test.

GINA also prohibits the Plan from requesting or requiring disclosure of genetic information of an individual or a family member of the individual, except as specifically allowed by GINA. To comply with this law, the Plan asks that you do not provide any genetic information when responding to any Plan request for medical information.

SECTION 1557 COMPLIANCE

United Welfare Fund complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. United Welfare Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

United Welfare Fund:

- Provides free aids and services to people with disabilities to communicate effectively with the Plan, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters.
- Information written in other languages

If a Participant needs these services, he or she should contact the United Welfare Fund Administrator: 718-658-4848 x 1211.

If a Participant believes that United Welfare Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, he or she can file a grievance with United Welfare Fund Administrator: 718-658-4848 x 1211. The Participant can file a grievance in person or by mail, fax, or email. If a Participant needs help filing a grievance, United Welfare Fund administrative personnel is available to help him or her.

Participants can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-797-2776

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-797-2776

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-797-2776 번으로 전화해 주십시오.

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-797-2776

Gujarati
□ચુ ના: જો તમે □જુ રાતી બોલતા હો, તો ની:□લ્ુ ક ભાષા સહાય સેવાઓ તમારા માટ□ ઉપલબ્ધ છે. ફોન કરો 1-877-797- 2776

Polish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-797-2776

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-797-2776

Arabic
(رقم هاتف الصم والبكم: 1-877-797-2776 اتصل برقم ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.

Tagalog – Filipino
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-797-2776

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните

French Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-797-2776

Hindi
ध् यान दें: यदि आप हदं बोलते हैं तो आपके लिए मफ्ु त में भाषा सहायता सेवाएं उपलब् ध हैं 1-877-797-2776 पर कॉल करें।

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-797-2776

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-797-2776

Urdu
1-877-797-2776 خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں

MODEL NEWBORN ACT'S DISCLOSURE

Group health plans and health insurance issuers generally 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 the 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not more than 48 or 96 hours as applicable.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you had or are going to have a mastectomy, you may be entitled to certain benefits under Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits under this Plan. If you would like more information on WHCRA benefits, please call the Fund Administrator at 718-658-4848, x1211.

YOUR RELATIONSHIP WITH LEA AND UNITED WELFARE FUND

In order to make choices about your health care coverage and treatment, the Plan Administrator believes that it is important for you to understand how LEA and United Welfare Fund works, and how it may affect you. LEA helps administer the Plan Sponsor's benefit plan in which you are enrolled. LEA does not provide medical services or make treatment decisions. This means:

- LEA and United Welfare Fund do not decide what care you need or will receive. You and your Physician make those decisions;
- LEA communicates to you about decisions whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

LEA and United Welfare Fund may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. LEA and United Welfare Fund will use individually identifiable information about you as permitted or required by law, including in operations and in research, and as permitted by the Plan's Notice of Privacy Practices. LEA and United Welfare Fund will use deidentified data for commercial purposes including research.

RELATIONSHIP WITH PROVIDERS

The relationships between the LEA, United Welfare Fund and Network providers are solely contractual relationships between independent contractors. Network providers are not LEA and United Welfare Fund's agents or employees, nor are they agents or employees of Anthem BCBS. The LEA and United Welfare Fund and any of its employees are not agents or employees of Network providers, nor is Anthem BCBS and any of its employees' agents or employees of Network providers.

LEA and United Welfare Fund do not provide health care services or supplies, nor do they practice medicine. Instead, the Plan and Anthem BCBS arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. BCBS's credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided. They are not the Plan Administrator's employees nor are they employees of Anthem BCBS. LEA and United Welfare Fund do not have any other relationship with Network providers such as principal-agent or joint venture. Anthem BCBS, LEA and United Welfare Fund are not liable for any act or omission of any provider.

Anthem BCBS is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

The Plan Administrator, the United Welfare Fund is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);

- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

YOUR RELATIONSHIP WITH PROVIDERS

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

INTERPRETATION OF BENEFITS

The Plan Administrator and the Plan have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Amendments; and
- make factual determinations related to the Plan and its Benefits.

The Plan Administrator and the Plan may delegate this discretionary authority to other persons or entities that provide services regarding the administration of the Plan.

In certain circumstances the Plan Administrator may, in its discretion, offer Benefits for services that would otherwise not be Covered Services. The fact that the Plan Administrator does so in any case shall not in any way be deemed to require the Plan Administrator to do so in other similar cases.

INFORMATION AND RECORDS

Your medical records are confidential documents. United Welfare Fund and the Plan may use your individually identifiable health information to administer the Plan and pay claims, and as otherwise permitted or required by law. United Welfare Fund and the Plan may request additional information from you to decide your claim for Benefits. United Welfare Fund and the Plan will keep this information confidential. United Welfare Fund and the Plan may also use your de-identified data as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish United Welfare Fund and the Plan with all information or copies of records relating to the services provided to you. United Welfare Fund and the Plan have the right to request this information at any reasonable time. This applies to all Participants, including enrolled Dependents whether they have signed the Participant's enrollment form. United Welfare Fund and LEA agree that such information and records will be considered confidential.

United Welfare Fund and LEA have the right to release all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as United Welfare Fund is required to do by law or regulation. During and after the term of the Plan, United Welfare Fund and LEA and its related entities may use and transfer the information gathered under the Plan in a de-identified format as allowed by law.

For complete listings of your medical records or billing statements United Welfare Fund recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from the Plan, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, United Welfare Fund and LEA will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. LEA's designees have the same rights to this information as does the Plan Administrator.

REBATES AND OTHER PAYMENTS

United Welfare Fund and the Claims Administrator may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. The United Welfare Fund and the Claims Administrator do not pass these rebates on to you, nor are they applied to your Annual Deductible or considered in determining your Copays or Coinsurance.

WORKERS' COMPENSATION

Injuries and diseases covered under any Workers' Compensation program are excluded from coverage under this Plan.

FUTURE OF THE PLAN

Although United Welfare Fund expects to continue the Plan indefinitely, the Plan Administrator reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Plan Administrator's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If United Welfare Fund does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Participants will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Participants may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to United Welfare Fund and others as may be required by any applicable law.

FRAUD

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact or makes material omissions of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant or any other entity submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire family unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30-day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

PROTECTION AGAINST CREDITORS

To the extent this provision does not conflict with applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his or her spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

BINDING ARBITRATION

NOTE: The Participant is enrolled in a plan provided by the Plan Administrator that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules and is not subject to mandatory binding arbitration. To the extent this provision does not conflict with applicable law, if a Participant or any other individual or entity has any dispute which does not involve an adverse benefit decision, this Binding Arbitration provision applies.

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small

claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, as chosen, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

UNCLAIMED SELF-INSURED PLAN FUNDS

In the event a benefit check or any other payment issued by the Claims Administrator or the Fund office for this self-insured Plan is not cashed within one year of the date of issue, the check or payment will be voided and the monies will be returned to this Plan and applied to the payment of current benefits and administrative expenses under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Claims Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits and administrative expenses under the Plan pursuant to ERISA, and any other applicable State law(s).

SECTION 14: GLOSSARY

This section includes definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Act of War – any act pertaining to military, naval or air operations in time of War.

Active – performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

Acute – The sudden onset of disease or injury, or a sudden change in the Participant's condition that would require prompt medical attention.

Admission – days of Inpatient services provided to a Participant.

Adverse Benefit Determination – means any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental, Investigational or Unproven or not Medically Necessary and Appropriate.

Affordable Care Act (ACA) – means the health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

Alcoholism – See "Substance Abuse/Substance Use Disorder" below.

Allowable Charge(s) – the Maximum Allowable Charge for any Medically Necessary and Appropriate, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Charges shall in no event exceed the Other Plan's Allowable Charges.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether it is actually made.

Ambulance Service – is a medically necessary medical transportation provider, licensed by the state, which provides local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

Ambulatory Surgical Centers - A facility currently licensed by the appropriate state regulatory agency for the provisions of surgical and related medical services on an outpatient basis. Annual Deductible (or Deductible) – the amount you must pay for Covered Services in a calendar year before the Plan will begin paying Out-of-Network Benefits in that calendar year.

Approved Clinical Trial – means a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The Affordable Care Act requires that if a "qualified individual" is

in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate, or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of-network benefits are otherwise provided under the Plan.

Behavioral Interventions Based on Applied Behavioral Analysis (ABA) – Interventions or strategies, based on learning theory, that are intended to improve a person's socially important behavior. This is achieved by using instructional and environmental modifications that have been evaluated through scientific research using reliable and objective measurements. These include the empirical identification of functional relations between behavior and environmental factors.

Such intervention strategies include but are not limited to: chaining; functional analysis; functional assessment; functional communication training; modeling (including video modeling); procedures designed to reduce challenging and dangerous behaviors; prompting; reinforcement systems, including differential reinforcement, shaping and strategies to promote generalization.

Benefits – Plan payments for Covered Services, subject to the terms and conditions of the Plan and any Amendments.

Child Dependent – A person who: has not attained the age of 26; and is:

a) The natural born child or stepchild of you or your Spouse;

b) A child who is: (a) legally adopted by you or your Spouse; or (b) placed with you for adoption. But, proof of such adoption or placement must be furnished to Claims Administrator upon request;

c) You or your Spouse's legal ward. Proof of guardianship must be furnished upon request.

Claims Administrator – LEA and its affiliates, that provide certain claim administration services for the Plan.

Clean Claim – is a claim that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

Clinical Eligibility for Coverage – Services required diagnosing or treating an injury or sickness. Services must be known to be safe, effective and appropriate by most qualified practitioners who are licensed to treat that injury or sickness. Services must be performed safely at the appropriate level of care or services, and in the least costly setting required by the injury or sickness. Services must not be provided primarily for the convenience of: the patient; the patient's family; or the qualified practitioner.

Any service or supply that does not meet the plan's guidelines for clinical eligibility for coverage is excluded from coverage.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received. See "Approved Clinical Trial" above COBRA – see Consolidated Omnibus Budget

Reconciliation Act of 1985 (COBRA).

Coinsurance – the percent applied to Covered Charges (not including Deductibles) for certain Covered Services or Supplies to calculate benefits under the Plan. These are shown in the Schedule of Covered Services and Supplies. The term does not include Co-Payments. Unless the context indicates otherwise, the Coinsurance percentages shown in this SPD are the percentages that member will pay.

Compression stockings – garments that apply various levels of pressure to the feet or legs to improve blood flow and decrease swelling. These circulation stockings help treat and prevent many issues such as edema, phlebitis, varicose veins, lymphedema, and deep vein thrombosis.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires group health plan to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Co-Payment or Co-Pay – is that portion of eligible medical and prescription drug expenses for which you are financially responsible and are payable at the time services are rendered.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Covered Expense(s) – a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary and Appropriate service, treatment or supply, meant to improve a condition or Participant's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in your plan's Benefits Summary in the Appendix and as set forth elsewhere in this document.

Covered Services and/or Supplies – The types of services and supplies described in the Covered Services and Supplies section of this SPD. Except as otherwise provided in this SPD, the services and supplies must be furnished or ordered by a Provider and for Preventive Care, or Medically Necessary and Appropriate to diagnose or treat an Illness (including Mental Illness) or Injury.

Participant – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Participant.

Custodial Care – services that do not require special skills or training and that:

- aid in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – under this Plan is:

- Your legal Spouse, as determined under federal law, other than a legally separated spouse;
- Your unmarried or married children up to age 26. Coverage will be terminated at the end of the month in which the child turns 26 years old. Please see the definition of "Child Dependent" above.

Grandchildren of a Participant and the dependent(s) of a Dependent are not eligible for coverage.

Detoxification Facility – a health care facility licensed by the State as a Detoxification Facility for the treatment of alcoholism.

Developmental Disability – A person's severe chronic disability which:

a. is attributable to a mental or physical impairment, or a combination of them;

b. for the purposes solely of the provision of this Plan entitled "Diagnosis and Treatment of Autism and Other Developmental Disabilities", is manifest before age 22;

c. is likely to continue indefinitely;

d. results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; the capacity for independent living or economic self-sufficiency; and

e. reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are: (i) of lifelong or extended duration; and (ii) individually planned or coordinated.

Developmental Disability includes, but is not limited to, severe disabilities attributable to: intellectual disability; autism; cerebral palsy; epilepsy; spina-bifida; and other neurological impairments where the above criteria are met.

Diagnostic Services – Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

a) radiology, ultrasound and nuclear medicine;

b) lab and pathology; and

c) EKG's, EEG's and other electronic diagnostic tests.

Dialysis Treatment – The treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

DNA Testing – is a Genetic testing to determine whether someone has the BRCA1 or BRAC2 variant indicating a predisposition to breast cancer, a test to determine whether someone has a genetic variant associated with hereditary nonpolyposis colon cancer and a test for a genetic variant for Huntington's disease.

Durable Medical Equipment (DME) – medical equipment that is the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Some examples are: walkers; wheelchairs (manual or electric); hospital-type beds; breathing equipment; and apnea monitors.

Some examples of services and supplies that are not considered to be Durable Medical Equipment are: adjustments made to vehicles; furniture; scooters; all- terrain vehicles (ATVs); non-hospital-type beds; air conditioners; air purifiers; humidifiers; dehumidifiers; elevators; ramps; stair glides; emergency alert equipment; handrails; hearing aids, heat appliances; improvements made to the home or place of business; waterbeds; whirlpool baths; and exercise and massage equipment.

Eligible Expenses – a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Participant's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Eligible Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in your plan's Benefits Summary in the Appendix and as set forth elsewhere in this document.

Enrollment Date – The Enrollment Date is the Participant's first day of coverage under the SPD or, if earlier, the first day of the waiting period that must pass with respect to the Participant before the Participant is eligible to be covered under the Plan.

Emergency Care – is medical treatment provided for any of the following:

- A medical condition that comes on suddenly and is manifested by symptoms of such severity, including severe pain, that a prudent person with average knowledge of medicine could reasonably expect that the absence of immediate medical attention could result in:
  - Placing the health of the afflicted person in serious jeopardy; or
  - Causing serious dysfunction of any bodily organ or part; or
  - Causing serious disfigurement of the afflicted person.
- Treatment and services due to a non-work-related accident and rendered within 48 hours of such accident.
- Treatment and services due to a sudden onset of serious illness and rendered within 24 hours of such illness.
- Emergency situations such as uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose

of medication or poisoning, sudden paralysis or slurred speech, serious burns or cuts, and broken bones.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

Essential Health Benefits (EHB) – means, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of South Carolina as permitted by the Departments of Labor, Treasury, and Health and Human Services.

Exclusions – what the Plan does not cover as a Covered Service.

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Plan decides regarding coverage in a case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (subject to the "Exceptions" set forth below).

Exceptions:

- Approved Clinical Trials for which Benefits are available as described under Clinical Trials in Section 6, Covered Services.
- If you are not a participant in an Approved Clinical Trial as described under in Section 6, Covered Services, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by LEA and Anthem BCBS to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Facility – An entity or institution which provides health care services within the scope of its license, as defined by applicable law.

FDA – The Food and Drug Administration.

Health Care Provider or Provider – means a Hospital, ambulatory surgery facility, a diagnostic testing facility or a Physician.

Habilitation Services – Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Home Health Care – Nursing and other Home Health Care services rendered to a Participant in his/her

home. For Home Health Care to be covered, these rules apply:

- The care must be given on a part-time or intermittent basis, except if full-time or 24-hour services are Medically Necessary and Appropriate on a short-term basis.
- Continuing Inpatient stay in a Hospital would be needed in the absence of Home Health Care.
- The care is furnished under a physician's order and under a plan of care that: (a) is established by that physician and the Home Health Care Provider; (b) is established within 14 days after Home Health Care starts; and (c) is periodically reviewed and approved by the physician.

Hospice – A Provider which mainly provides palliative and supportive care for terminally ill or terminally injured people under a Hospice Care Program. To qualify, Provider must either be approved for its stated purpose by Medicare or accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospice Care Program – A health care program which provides an integrated set of services designed to provide Hospice care. Hospice services are centrally coordinated through an interdisciplinary team directed by a Practitioner.

Hospital – an institution rendering inpatient and outpatient services for the medical care of the sick or injured. It must be accredited as a Hospital by either the Joint Commission on Accreditation of Health Care Facilities or the Bureau of Hospitals of the America Osteopathic Association. A Hospital may be a general, Acute care, or a specialty institution, if it is appropriately accredited as such, and currently licensed by the proper state authorities.

Illness – is any bodily sickness or disease, including any congenital abnormality as diagnosed by a Physician and as compared to the person's previous condition. Expenses Incurred because of pregnancy, childbirth and related medical conditions are covered under the Plan to the same extent as any other Illness.

Incurred – An Eligible Expense is "Incurred" on the date the service is rendered, or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Eligible Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Eligible Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Inherited Metabolic Disease – A disease caused by an inherited abnormality of body chemistry for which testing is mandated

Injury – is any damage to a body part resulting from trauma from an external source.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Mammography – the process of using low-energy X-rays to examine the human breast for diagnosis and screening.

Types of mammography:

- 2D Mammogram produces two dimensional images of each breast
- 3D Mammogram or breast tomosynthesis produces many X-ray images of the breasts from multiple angles to create a digital 3-dimensionalrendering of internal breast tissue.

Maximum Allowable Charge (MAC) – will be a negotiated rate if one exists. In the absence of a negotiated rate, the Maximum Allowable Charge will be calculated by the Plan Administrator considering any or all of the following:

An amount determined by the Claims Administrator as the least of the following amounts: (a) the actual charge made by the Provider for the service or supply; or (b) the amount determined by the Plan Administrator to be Usual and Customary, as defined herein.

Unless otherwise indicated on the Schedule of Benefits, no coverage is available for services performed by Providers or facilities that are not In-Network. Regarding the Schedule of Benefits:

The Schedule of Benefits may specify the type of network recognized by the Plan. If no such network is specified, please contact the Claims Administrator.

The Plan is not responsible for the balance of any Out of Network provider charge.

The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Appropriate and Reasonable service.

Medicaid – a federal program administered and operated individually by participating state and territorial

governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary and Appropriate – is services or supplies provided by a licensed medical care provider that the Plan determines are:

a) appropriate for the symptoms and diagnosis or treatment of the patient's condition, illness, disease or injury;

b) provided for the diagnosis or the direct care and treatment of the patient's condition, illness, disease or injury;

c) safe, effective and in accordance with standards of good medical practice;

d) not primarily for the convenience of the patient, the patient's family; or the qualified Provider;

e) performed in a cost-effective manner as compared to alternative interventions, including no intervention, where cost effective does not necessarily mean lowest cost, provided that the diagnosis or treatment of the applicable illness, injury or disease, the service is: (1) not costlier than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;

f) not experimental or investigative; and

g) The most appropriate supply or level of service that can safely be provided to the patient. When applied to hospitalization, this further means that the patient requires acute care as an inpatient due to the nature of the services rendered or the patient's condition, and the patient cannot receive safe or adequate care as an outpatient.

Any service or supply that does not meet the Plan's guidelines for coverage is excluded from coverage. The fact that a provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies medically necessary and appropriate and does not guarantee payment. The Plan reserves the right to determine, in its sole judgment, whether a Service is medically necessary and appropriate. No benefits hereunder will be provided unless the Plan determines that the Service or supply is medically necessary and appropriate. Eligible expenses are subject to the Claims Administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

Medical Record Review – the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA – mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that all of the following requirements are met:

a) The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

b) The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan).

Mental Illness – is an emotional or mental disorder, whether organic or non-organic, whether of biological, nonbiological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions and drug, alcohol or Chemical Dependency. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, Chemical Dependency disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders,

conditions, and illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

Morbid Obesity – is having a Body Mass Index (BMI) equal to or greater than 40. BMI is your weight in kilograms divided by your height in meters squared. Coverage is available for certain non-experimental and scientifically proven, surgical treatment by a qualified practitioner. Pre-authorization is required, or benefits will not be payable under the plan. The plan reserves the right to determine whether the treatment is eligible for coverage. Benefits do not include nutritional supplements, body composition or underwater weighing procedures, exercise therapy, weight control or reduction programs.

Network – when used to describe a provider of health care services, this means a Provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network.

Network Provider – A Physician, Certified Nurse Midwife, Hospital, Skilled Nursing Facility, Home Health Care Agency, or any other duly licensed or certified institution or health professional under contract with Anthem BCBS to provide Covered Services to our Participants. A list of Network Providers and their locations is available to you upon enrollment or upon request. This list will be revised from time to time by Anthem BCBS.

Non-Covered Charges – Charges for services and supplies which:

a) do not meet this Plan's definition of Covered Charges;

b) exceed any of the coverage limits shown in this SPD; or

c) are specifically identified in this SPD as Non-Covered Charges.

Open Enrollment Period – A period of time, established by the Plan Sponsor, during which eligible persons may be enrolled.

Out-of-Network – when used to describe a provider of health care services, this means a Provider that does not have a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network.

Out-of-Pocket Maximum – the maximum amount you pay every plan year. Please refer to your plan's Benefits Summary in the Appendix for the Out-of-Pocket Maximum amount.

Participant – an individual who meets the eligibility requirements specified in the Plan, as described under Eligibility. A Participant must live and/or work in the United States.

Patient Protection and Affordable Care Act (PPACA) – means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, nurse practitioner, clinical social worker, physician assistant, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The United Welfare Fund Medical Plan.

Plan Administrator – The Board of Trustees of the United Welfare Fund or its designee.

Plan Sponsor – The Board of Trustees of the United Welfare Fund or its designee.

Polysomnography – is a Sleep Study to diagnose sleep disorders (i.e. Sleep Apnea, Insomnia, Narcolepsy).

Preauthorization (AKA Precertification) – enables the Preauthorization Vendor to review the Medical Necessity of a proposed service or treatment including the determination of a proposed site of care, manage benefit limitations, and whether the service will be performed by a Network Provider. Preauthorization allows the Preauthorization Vendor to notify the Participant or the Participant's Provider regarding coverage before the service is provided.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Prescription Drugs – Drugs, biological and compound prescriptions which: (a) are dispensed only by prescription; and (b) are required to show on the manufacturer's label the words: "Caution-Federal Law Prohibits Dispensing without a Prescription." The term includes: prescription female contraceptives; insulin; and may include other drugs and devices (e.g., syringes; glucometers; over-the-counter drugs mandated by law), as determined by Claims Administrator. For this provision, "prescription female contraceptives" are drugs or devices, including, but not limited to, birth control pills and diaphragms, that: (i) are used for contraception by a female; (ii) are approved by the FDA for that purpose; and (iii) can only be purchased with a prescription written by a health care professional licensed or authorized to write prescriptions.

Preventive Care Services – are the recommended preventive services identified by the federal Patient Protection and Affordable Care Act (PPACA). These services are described in the United States Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the CDC, and Health Resources and Services Administration (HRSA) Guidelines, including the American Academy of Pediatrics Bright Futures periodicity guidelines.

You may call Customer Service using the number on Your ID card for additional information about these services or view the federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/

Primary Care Physician (PCP) – a Network Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Prior to Effective Date or After Termination Date – are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless continuation of benefits applies.

Qualified Medical Child Support Order (QMCSO) – creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies. A QMCSO will be recognized as "qualified" comply with applicable requirements of federal law.

Reasonable and/or Reasonableness – in the Plan Administrator's discretion, services or supplies, or fees for services or supplies, which are necessary for the care and treatment of illness or Injury not caused by the treating Provider's error or mistake. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or illness necessitating the service(s) and/or charge(s).

This determination will consider but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) The Centers for Medicare and Medicaid Services (CMS) and (c) The Food and Drug Administration. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

To be Reasonable, service(s) and/or fee(s) must also be in compliance with generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator.

The Plan Administrator reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically because of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Semi-private Room – a room with two or more beds. When an Inpatient Stay in a Semi-Private Room is a Covered Service, the difference in cost between a Semi-Private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi- Private Room is not available.

Services – the Medically Necessary services paid for or arranged for you by the Plan under the terms and conditions of this SPD.

Skilled Nursing Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or

transferring from a bed to a chair;

- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Special Care Unit – A part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff and special equipment and supplies on hand at all times. Some types of Special Care Units are:

a) intensive care units;

b) cardiac care units;

c) neonatal care units; and

d) burn units.

Substance Abuse and/or Substance Use Disorder – Any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as outlined below.

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:

a) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household).

b) Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).

c) Craving or a strong desire or urge to use a substance.

Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

The fact that a disorder is listed in the DSM does not mean that treatment of the disorder is covered by the Plan.

Substance Abuse Centers – Facilities that mainly provide treatment for people with Substance Abuse problems or Alcoholism. To qualify as a Substance Abuse Center, the facility must be accredited for its stated purpose by the Joint Commission or approved for its stated purpose by Medicare.

Summary Plan Description (SPD) – This SPD administered by LEA, including the summary of coverage under your plan's Benefits Summary in the Appendix and any attached Amendments.

Surgery – is any Medically Necessary and Appropriate operative or diagnostic procedure performed in the treatment of an Injury or illness by instrument or cutting procedure through an incision or any natural body opening.

Therapy Services – The following services and supplies when they are:

1. ordered by a Practitioner;
2. performed by a Provider;
3. for a Participant who is a Hospital Inpatient or Outpatient, or a recipient of care given by a Home Health Agency; and
4. Medically Necessary and Appropriate for the treatment of a Participant's Illness or Accidental Injury.

Chelation Therapy – The administration of drugs or chemicals to remove toxic concentrations of metals from the body.

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

Cognitive Rehabilitation Therap – Retraining the brain to perform intellectual skills that it was able to perform prior to disease, trauma, Surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment – The treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy – The administration of antibiotic, nutrient, or other therapeutic agents by direct infusion.

Occupational Therapy – The treatment to develop or restore a physically disabled person's ability to perform the ordinary

tasks of daily living.

Physical Therapy – The treatment by physical means to: relieve pain; develop or restore normalfunction; and prevent disability following Illness, Injury or loss of limb.

Radiation Therapy – The treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes the rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy – The introduction of dry or moist gases into the lungs.

Hyperbaric Oxygen Therapy (HBOT) – involves breathing pure oxygen in a pressurized room or tube.

Hyperbaric Oxygen Therapy – is a well-established treatment for decompression sickness. Conditions treated with HBOT include serious infections, bubbles of air in your blood vessels, wounds that won't heal because of diabetes or radiation injury, severe anemia, brain abscess, gangrene, infection of skin bone and more.

Speech Therapy – Therapy that is by a qualified speech therapist and is described in a., b. or c:

a) Speech therapy to restore speech after a loss or impairment of a demonstrated, previous ability to speak. Two examples of speech therapy that will not be covered are: (i) therapy to correct pre-speech deficiencies; and (ii) therapy to improve speech skills that have not fully developed.

b) Speech therapy to develop or improve speech to correct a defect that both existed at birth; and impaired or would have impaired the ability to speak.

c) Regardless of anything in a. or b. above to the contrary, speech therapy needed to treat a speech impairment of a Participant diagnosed with a Developmental Disability.

For the purposes of this Plan, "Speech Therapy" shall also be deemed to include feeding therapy, when Medically Necessary and Appropriate, designed to facilitate normal feeding patterns.

Total Disability or Totally Disabled – A disability that result from a bodily Injury or disease that wholly prevents the person from engaging in any gainful work as determined by the Plan Administrator.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received).
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), United Welfare Fund may, at their discretion, consider an otherwise Unproven Service to be a Covered Service for that Sickness or condition. Prior to such a consideration, United Welfare Fund must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Service is solely at United Welfare Fund's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

Usual and Customary (U&C) – means Covered Expenses which are identified by the Plan Administrator. The Usual and Customary

amount for a given item of service or supply will typically be 100% of the Medicare Fee Schedule. If the Medicare Fee Schedule does not include a service, the reimbursement rate will be the 80th percentile of the Usual Customary and Reasonable ("UC&R") charges, using industry-standard data sources. If both the Medicare Fee Schedule does not include a service, and a UC&R charge is not available at the 85th percentile using industry-standard data sources, the service will be priced at 50% of billed charges. The Plan Administrator may, in its discretion, take into consideration any or all of the following, if the Plan Administrator deems it appropriate: the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply; the cost to the Provider for providing the services; and the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are in the same geographic locale in which the charge was Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Utilization Review – The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

War – Includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization.

Work Related – means an Injury or Illness arising out of or during one's employment, whether or not the person properly asserts his or her rights and whether or not any recovery is received.

You or Your – refers to the Participant, unless the context clearly indicates otherwise.

SECTION 15: IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in the Glossary. While you may not need this information for your day-to-day participation, it is information you may find important.

PLAN SPONSOR AND ADMINISTRATOR

The Board of Trustees of the United Welfare Fund is the Plan Sponsor and Plan Administrator of the United Welfare Fund Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

United Welfare Fund
145 Huguenot Street - Suite 100
New Rochelle, NY 10801
Phone: 1-718-658-4848

CLAIMS ADMINISTRATOR

Leading Edge Administrators is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with United Welfare Fund. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Administrator's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Administrator's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

Leading Edge Administrators
14 Wall Street, Suite 5B
New York, NY 10005

AGENT FOR SERVICE OF LEGAL PROCESS

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process:

United Welfare Fund
145 Huguenot Street - Suite 100
New Rochelle, NY 10801
Phone: 1-718-658-4848

Legal process may also be served on the Plan Administrator.

OTHER ADMINISTRATIVE INFORMATION

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name: United Welfare Fund – Welfare Division

Group Number: 000USU834, 000USX834

Employer ID: 11-1823976

Plan Type: Welfare benefits plan

Plan Year: April 1 – March 31

Plan Administration: Self-Insured

Funding of Benefits Contributions from participating employers

and, in some cases, employees pursuant to a

collective bargaining agreement or other writing

Source of Benefits: Assets of United Welfare Fund

Applicable Law: ERISA

COLLECTIVE BARGAINING AGREEMENT(S)

This Plan is maintained pursuant to one or more collective bargaining agreements. A copy of the agreement(s) may be obtained by Participants and beneficiaries upon written request to the Plan Administrator and is also available for examination by Participants and beneficiaries in the Plan Administrator's principal office.

YOUR ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents –

including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration; and

- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan because of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

You will be provided a Certificate of Creditable Coverage (COCC) in writing, free of charge, from United Welfare Fund:

- when you lose coverage under the Plan;
- when you become entitled to elect COBRA;
- when your COBRA coverage ends;
- if you request a certificate of creditable coverage before losing coverage; or
- if you request a certificate of creditable coverage up to 24 months after losing coverage.

You may request a certificate of creditable coverage by calling the toll-free number on your ID card. ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If the Plan's 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (800)-998-7542.

The Plan's Benefits are administered by United Welfare Fund, the Plan Administrator. LEA is the Claims Administrator and processes claims for the Plan and provides appeal services; however, LEA and United Welfare Fund are not responsible for any decision you or your Dependents make to receive treatment, services or supplies from a provider. LEA and United Welfare Fund are neither liable nor responsible for the treatment, services or supplies you receive from providers.

SECTION 16: HIPPA PRIVACY PRACTICES

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 1-877-797-7226

The following is a description of certain uses and disclosures that may be made by the Plan of your health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"):

DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI") TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
- Notify Participants of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the health breach notification rule;
- Notify the Federal Trade Commission of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the health breach notification rule;
- Report to the Plan any PHI uses or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI to the Participant in accordance with the privacy standards; • Make a Participant's PHI available for the Participant to amend to the extent required by the privacy rules;
- Make available the information required to provide an accounting of disclosures; • Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the privacy standards;
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Ensure that adequate separation between the Plan and the Plan Sponsor exists, as required by the privacy rules.

The Claims Administrator is the contact person for all PHI information requests.

In the event any of the individuals do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Claims Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO THE PLAN SPONSOR

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan Sponsor agrees to comply with the above privacy rule provisions.

Pursuant to the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has dis-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE

The Plan Sponsor authorizes and directs the Plan, through the Claims Administrator or the Third-Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

OTHER DISCLOSURES AND USES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the privacy standards. HIPAA has several special rules, and the information presented covers only basic points.

If you want to know more about how HIPAA applies to group health plans, the Department of Labor offers a booklet "Questions and Answers: Recent Changes in Health Care Law." You may request this booklet free of charge by calling (1-800) 998-7542.

If you are in a Marketplace plan, your eligibility for this medical plan may have an impact on the cost of your Marketplace plan (you may not be eligible for a subsidy for such coverage) if you choose to remain in the Marketplace plan. Contact your Marketplace plan directly for information about your rates and any other questions. If you do not know the contact information, you may find it at www.healthcare.gov or call 1-800-318-2596.

AMENDMENT NO. # 1

United Welfare Fund Welfare Division

Effective March 1, 2020, the United Welfare Fund Welfare Division (the "Plan") is hereby amended to provide enhanced health benefits associated with diagnosis and testing for the 2019 Novel Coronavirus (COVID-19) without cost-sharing. This Amendment will terminate upon the expiration of the public health emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d. All other sections of the Plan remain unchanged.

1. The Plan **Summary of Benefits** is amended to include the following line item(s) the medical benefits grid:

Covered Medical Expenses	Network	Out-of-Network
Diagnosis and Testing for the 2019 Novel Coronavirus (COVID-19)	Covered at 100% $0 cost share	Covered at 100% $0 cost share

2. The plan **Medical Benefits** is amended to include the following benefit language for "2019 Novel Coronavirus (COVID-19)".

2019 Novel Coronavirus (COVID-19). Covered Expenses associated with diagnosis and testing for COVID-19 include the following:

- *Diagnosis and Tests.* The following items are covered at 100%, deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise-applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require Pre-Certification. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the Provider's website, or such other amount as may be negotiated by the Provider and Plan.
    - In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy **one** of the following conditions:
        - that are approved, cleared, or authorized by the FDA;
        - for which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
        - that are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
        - that are deemed appropriate by the Secretary of Health and Human Services.
    - Items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.

- *Qualifying Coronavirus Preventive Services*. The following items are covered at 100%, deductible waived, and do not require Pre-Certification.
    - An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and
    - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- *Inpatient Hospital Quarantines*. There may be times when Participants with the virus need to be quarantined in a Hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the Hospital for public health reasons. Such charges will not be denied solely because otherwise-applicable Medically Necessary requirements would not indicate a need for a private room.
- *Telehealth and Other Communication-Based Technology Services*. Participants can communicate with their doctors or certain other practitioners without going to the doctor's office in person. This is recommended if a Participant believes he or she has COVID-19 symptoms.
- *Requests for Prescription Refills*. When considering whether to cover a greater-than-30-day-supply of drugs, the Plan and its Prescription Drug Plan Administrator will, on a case-by-case, basis, consider each request and make decisions based on the circumstances of the patient.

Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

3. The Plan **Continuation of Coverage** is amended to include the following provision(s):

Employer Continuation Coverage

Eligible Participants may seek to continue coverage during the duration of the public health emergency upon the occurrence of any of the following:

1. Furlough
2. Short-Term Disability Leave
3. Long-Term Disability Leave
4. Americans with Disabilities Act (ADA) Leave; A non-FMLA leave granted by the Employer in accordance with the ADA..
5. Leave of Absence (not meeting the definition of FMLA Leave)
6. COVID-19 Leave. Leave taken in accordance with the Families First Coronavirus Response Act "FFCRA," including the Emergency Family and Medical Leave Expansion Act (see the Plan's "Continuation During Family and Medical Leave Act (FMLA)" section) and Emergency Paid Sick Leave Act: coverage will continue for the duration of the permitted leave under the FFCRA, as amended.

The above-noted leave(s) run concurrently with FMLA, USERRA, or any state-mandated family or medical leave, and/or any other applicable leaves of absence, as applicable and subject to applicable law. At the end of the period(s) listed above, the Participant's coverage will be deemed to have terminated for purposes of Continuation of Coverage under COBRA.

4. In the **Continuation During Family and Medical Leave Act (FMLA) Leave** section, the following provision has been added:

FFCRA

The Families First Coronavirus Response Act (FFCRA) requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020. Eligibility will be extended through any such leave in the same manner as for traditional FMLA leave.

This amendment includes compliance with any future additions to or modifications of the Families First Coronavirus Response Act (FFCRA), Coronavirus Aid, Relief, and Economic Security Act (CARES Act), and any future regulations related to the Novel Coronavirus COVID-19.

All other sections of the Plan remain unchanged.

AMENDMENT #2 TO THE

United Welfare Fund Welfare Division

SUMMARY PLAN DESCRIPTION

The Plan Sponsor United Welfare Fund as the settlor of the Plan, amends the United Welfare Fund Welfare Division Summary Plan Description (SPD). This Summary of amendments supplements the SPD previously provided to you. You should retain this document with your copy of the SPD.

Text of the Amendment

This amendment updates the Plan Sponsor, Plan Administrator, and Agent for Service of Legal Process address to the following:

United Welfare Fund
145 Huguenot Street
Suite 100
New Rochelle, NY 10801

This amendment updates the Claims Administrator address to the following:

Leading Edge Administrators
8162 Woodland Center Blvd.
Tampa, FL 33614

This amendment updates the Claims Review and Appeals address to the following:

United Welfare Fund
c/o Leading Edge Administrators
Attention: Appeals Department
8162 Woodland Center Blvd.
Tampa, FL 33614

In Witness Whereof, the Plan Sponsor has caused this Plan Amendment to be executed, effective June 1, 2021.

UNITED SERVICE WORKERS UNION

WELFARE DIVISION

AMENDMENT TO THE
SUMMARY PLAN DESCRIPTION
FOR THE UNITED WELFARE FUND – WELFARE DIVISION

The Board of Trustees (the "Trustees") of the United Welfare Fund - Welfare Division (the "Plan") hereby amends the Summary Plan Description for the United Welfare Fund - Welfare Division (the "SPD") as follows, effective August 1, 2021, unless otherwise stated in the body of the Amendment:

The SPD is amended, as follows:

1. SECTION 6: COVERED SERVICES is amended by adding the following numbered sub-section in the section entitled PREVENTIVE CARE:

   8. Waiver of Cost Sharing for Detection of COVID-19
   Effective March 18, 2020 and through the end of the national emergency as declared by the federal government, the UWF will now cover the following services from a health care provider at 100% of the Allowed Charge, with no cost sharing to you:

   - Diagnostic tests that detect SARS-CoV-2 or the virus that causes COVID-19, including the administration of such tests, for the following types of tests:
     - Tests to detect the virus that are approved, cleared, or authorized by certain sections of the Federal Food, Drug and Cosmetic Act (the Drug Act)
     - Tests for which the developer has requested, or intends to request, emergency use authorization under the Drug Act (and where such authorization has not been denied)
     - Tests developed in and authorized by a State that has notified HHS of its intention to review tests to diagnose COVID-19; and
     - Tests determined appropriate by HHS.
   - Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the test described above, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.

This means that there will be no deductibles, copayments, or coinsurance, as applicable, for COVID-19 testing.

Further, effective March 18, 2020 and through the end of the national emergency as declared by the federal government, the above services and products are not subject to any medical management requirements. This means that you do not have to get precertification/prior authorization from the UWF to have the tests or those visits covered.

You can find additional information from the Centers of Disease Control and Prevention (CDC) on COVID-19 that includes helpful information for you and your family. It is important to make sure you are getting your information from a reputable source such as https://www.cdc.gov/coronavirus/2019-ncov/about/index.html

2. SECTION 6: COVERED SERVICES is further amended by deleting sub-section H. Online Doctor visits in the section entitled SPECIALTY CARE and replacing it with the following sub-section:

H. Online Doctor Visits/Telehealth
Live Online video chat with licensed doctors provided by Anthem Blue Cross Blue Shield at: https://livehealthonline.com/ or on the phone at: 1-888-548-3432.

Effective March 18, 2020 and through the end of the national emergency as declared by the federal government, the UWF will cover telehealth visits. This means that you can now have an office visit with your doctor by phone or over the internet, and it will be covered by the UWF just like an in-person office visit. You will be responsible for the applicable cost sharing for the primary care or specialist physician visit (e.g., in-network copayment or the out-of-network deductible and coinsurance, as applicable).

Telehealth visits gives you quick and easy access to a doctor wherever you are. You can talk to a physician without leaving your house. It has been recommended that participants use telehealth when possible to help prevent the spread of infection and improve access to care. It is a safe and effective way to receive medical guidance for many medical issues, including those related to COVID-19, from your home using your telephone, smartphone, tablet, or computer with a web cam (depending on your doctor). Many doctors can determine if testing is necessary through a virtual visit. Call your doctor to see if they offer this service.

3. SECTION 9: CLAIMS PROCEDURES is amended by deleting the Assignments sub-section and replacing it with the following sub-section:

PROHIBITIONS ON ASSIGNMENT OR GRANTS OF POWERS OF ATTORNEY BY YOU
Coverage and your rights and benefits under this Plan, including, but not limited to, the right to receive payment for benefits, are personal to you and may NOT be assigned in whole or in part to any person or entity. A direction to pay a provider is NOT an assignment of any right or benefit under this Plan or of any legal or equitable

right to institute a court proceeding or take any action under any law of the United States or any individual State. This Plan will not accept your assignment to any person or entity, including, but not limited to, purported assignments to health care providers.

In addition, this Plan will not accept a Power of Attorney that purports to grant powers and authority to act on your behalf to any person or entity other than to immediate family members. The definition of immediate family member is to be determined by the Plan Administrator, and includes your spouse, your parents, and your children, and may include another person related to you by blood or marriage.

4. SECTION 13: OTHER IMPORTANT INFORMATION is amended by adding the following sub-section:

COMPLIANCE WITH FEDERAL, STATE AND LOCAL LAWS
The United Welfare Fund complies with applicable Federal, State, and Local laws. However the United Welfare Fund does not and cannot certify that your Employer is in compliance with its obligations under Federal, State and Local laws, including, but not limited to: the Employee Retirement Income Security Act, the Immigration Reform and Control Act, the Rehabilitation Act, the Patient Protection and Affordable Care Act, the Consolidated Omnibus Budget Reconciliation Act, Title VII of the Civil Rights Act, the Reconstruction Era Civil Rights Acts, the Civil Rights Act of 1991, the Equal Pay Act, the National Labor Relations Act, the Family and Medical Leave Act, the Fair Labor Standards Act, the Americans With Disabilities Act, the Fair Credit Reporting Act, the Age Discrimination in Employment Act, the Older Workers Benefit Protection Act, the New York State Human Rights Law, the New York Home Care Worker Wage Parity Law, the New York wage and hour laws, the New York Constitution, and any other Federal, State, or Local law, regulation, order or ordinance.

5. The amendments contained herein shall be effective on August 1, 2021, unless otherwise stated in the body of the Amendment, and shall continue in effect thereafter until further action of the Trustees. Except as amended, all provisions of the SPD remain effective and unaltered.

Dated: July 21, 2021
New Rochelle, New York

UNITED WELFARE FUND

WELFARE DIVISION

SUMMARY OF MATERIAL MODIFICATIONS

CHANGES TO MEDICAL BENEFITS PURSUANT TO THE NO SURPRISES ACT

Effective April 1, 2022

This document is a Summary of Material Modifications ("SMM") intended to notify you of important changes made to certain medical benefits under the United Welfare Fund - Welfare Division (the "Plan"). You should take the time to read this SMM carefully and keep it with a copy of the Summary Plan Description ("SPD") that was previously provided to you. If you have any questions regarding these changes to the Plan, please contact the Fund Office.

Effective April 1, 2022, the Fund is implementing a number of improvements to the Plan to comply with the No Surprises Act (the "NSA"). This SMM advises you of changes to certain Plan medical benefits in order to comply with the NSA.

The NSA was signed into law in December 2020 and protects patients from "balance billing" for Out-of-Network Emergency Services with respect to an Emergency Medical Condition in hospital emergency rooms and in certain independent freestanding emergency departments, Out-of-Network Air Ambulance Services, and certain non-emergency services performed by an Out-of-Network provider at an In-Network facility (collectively "No Surprises Services" - see the Definitions at the end of this SMM).

You are still encouraged to use In-Network facilities and participating providers whenever possible. Please review these changes carefully and contact the Fund Office with any questions that you may have.

Effective April 1, 2022, eligible participants receiving No Surprises Services will only be responsible for paying their In-Network cost sharing and cannot be balance billed by the Provider or facility for No Surprises Services, except in the limited situations where the notice and consent exception is applicable, as described below.

We describe the changes to your benefits, as follows:

Emergency Services

The NSA requires Emergency Services (see the Definitions at the end of this SMM) to be covered as follows:

1. Without the need for any prior authorization determination, even if the services are provided on an Out-of-Network basis;

2. Without regard to whether the health care Provider furnishing the Emergency Services is an In-Network Provider or an In-Network emergency facility, as applicable, with respect to the services;

3. Without imposing any administrative requirement or limitation on Out-of-Network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from In-Network Providers and In-Network emergency facilities;

4. Without imposing cost-sharing requirements on Out-of-Network Emergency Services that are greater than the requirements that would apply if the services were provided by an In-Network Provider or In-Network emergency facility;

5. By calculating the cost-sharing requirement for Out-of-Network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount (see the Definitions at the end of this SMM) for the services; and

6. By counting cost-sharing payments you make with respect to Out-of-Network Emergency Services toward your deductible (if applicable) and Network Out-of-Pocket Maximum in the same manner as Emergency Services received from an In-Network Provider or In-Network emergency facility.

Non-Emergency Items or Services Furnished by an Out-of-Network Provider at an In-Network Facility

The NSA requires non-emergency items and services furnished by an Out-of-Network Provider at an In-Network Health Care Facility (see the Definitions at the end of this SMM) to be covered as follows:

1. Without imposing cost-sharing requirements that are greater than the requirements that would apply if the items or services were provided by an In-Network Provider;

2. By calculating the cost-sharing requirement as if the total amount that would have been charged for the items or services were equal to the Recognized Amount (see the Definitions at the end of this SMM) for the items or services; and

3. By counting cost-sharing payments you make toward your deductible (if applicable) and Network Out-of-Pocket Maximum in the same manner as those items or services received from an In-Network Provider.

Notice and Consent Exception: Non-emergency items or services performed by an Out-of-Network Provider at an In-Network facility will be covered based on the Out-of-Network cost-sharing if:

a. At least 72 hours before the day of the appointment (or on the date the appointment is scheduled if the appointment is scheduled within 72 hours of the appointment date, but no later than 3 hours in advance of items or services being rendered in the case of a same-day appointment), you are supplied with a written notice, as required by federal law, that states, among other things, the Provider is an Out-of-Network Provider with respect to the Plan, the estimated charges for your treatment, prior authorization or other care management limitations may be required in advance of receiving such treatment, and consent is optional and you may elect to seek care from an In-Network Provider; and

b. You give informed consent to treatment by the Out-of-Network Provider, acknowledging, among other things, that you have been provided with the required notice and you understand that treatment by the Out-of-Network Provider may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services (see the Definitions at the end of this SMM) and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

Out-of-Network Air Ambulance Services

If you receive Air Ambulance Services that are otherwise covered by the Plan from an Out-of-Network Provider, those services will be covered by the Plan as follows:

- The Air Ambulance Services received from an Out-of-Network Provider will be covered with a cost-sharing requirement that is the same as the cost-sharing requirement that would apply if the Air Ambulance Services had been furnished by an In-Network Provider.
- In general, you cannot be balance billed for Air Ambulance Services. Your cost-sharing will be calculated as if the total amount that would have been charged for the Air Ambulance Services by an In-Network Provider were equal to the lesser of the Qualifying Payment Amount (see the Definitions at the end of this SMM) or the billed amount for the Air Ambulance Services.
- Any cost-sharing payments you make with respect to covered Air Ambulance Services will count toward your In-Network deductible (if applicable) and Network Out-of-Pocket Maximum in the same manner as Air Ambulance Services received from an In-Network Provider.

Continuity of Coverage

If you are a Continuing Care Patient (see the Definitions at the end of this SMM), and the Fund terminates its In-Network contract with an In-Network Provider or facility, or your benefits are

terminated because of a change in terms of the Providers' and/or facilities' participation in the Network:

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the Provider or facility; and
2. You will be allowed up to ninety (90) days of continued transitional care at In-Network cost sharing to allow for a transition of care to an In-Network Provider.

Provider Directory

A list of In-Network United Healthcare or Blue Cross Blue Shield Providers and facilities and their directory information is available to you without charge by visiting https://member.uhc.com/myuhc or https://www.bcbs.com or by calling the phone number on your ID card.

If you obtain and rely upon incorrect information about whether a Provider is an In-Network Provider from the Plan's website, its provider directory, or its administrators, the Plan will apply the In-Network deductible (if applicable), the In-Network Out-of-Pocket Maximum and In-Network cost-sharing to your claim, even if the Provider was an Out-of-Network Provider at the time the service was rendered.

For more information and an up-to-date list of In-Network Providers, you may also call the Fund Office.

Complaint Process

If you believe you've been wrongly billed, or otherwise have a complaint under the NSA, you may contact the federal government's NSA Helpdesk at 1-800-985-3059, the Fund Office, or the Employee Benefit Security Administration (EBSA) toll free number at 1-866-444-3272.

External Review Process of Certain Coverage Determinations

If your claim for benefits related to No Surprises Services has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for External Review of the determination. Please contact the Fund Office for a copy of the Fund's External Review procedures.

New Definitions Implemented from the NSA

To implement the protections of the NSA, effective April 1, 2022, the Fund is adopting the following new/revised definitions of terms in the SPD as follows:

Air Ambulance Services means medical transport by helicopter or airplane for patients.

Ancillary Services means, with respect to an In-Network health care facility, the following:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
2. Items and services provided by assistant surgeons, hospitalists, and intensivists;
3. Diagnostic services, including radiology and laboratory services; and

4. Items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish such item or service at such facility.

Continuing Care Patient means an individual who, with respect to a Provider or facility, is: (1) receiving a course of treatment for a "Serious and Complex Condition" from the Provider or facility (see the Definitions at the end of this SMM); (2) scheduled to undergo non-elective surgery from the Provider (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy from the Provider or facility; (4) determined to be terminally ill and receiving treatment for the illness from such Provider or facility; or (5) undergoing a course of institutional or inpatient care from the Provider or facility.

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including 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:

1. Serious impairment to bodily functions; or

2. Serious dysfunction of any bodily organ or part; or

3. Placing the health of an individual (or, with respect to a pregnant person, the health of the person or the unborn child) in serious jeopardy.

Emergency Services means, with respect to an Emergency Medical Condition, the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

3. Items and services furnished by an Out-of-Network Provider or Out-of-Network emergency facility (regardless of the department of the hospital in which such items or services are furnished) after you are stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraph (1) were furnished until:

a. The Provider determines that you are able to travel using nonmedical transportation or nonemergency medical transportation to an available In-Network Provider or facility located within a reasonable travel distance, taking into account your medical condition; and

b. You are supplied with a written notice, as required by federal law, that states, among other things, the Provider is an Out-of-Network Provider with respect to the Plan, the estimated charges for your treatment, prior authorization or other care management limitations may be required in advance of receiving such treatment, the names of any In-Network Providers at the facility who are able to treat you, and that consent is optional and you may elect to be referred to one of the In-Network Providers listed; and

c. You give informed consent to continued treatment by the Out-of-Network Provider, acknowledging, among other things, that you have been provided with the required notice and you understand that continued treatment by the Out-of-Network Provider may result in greater cost to you.

Health Care Facility (for non-emergency services) means each of following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);

2. A hospital outpatient department;

3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

No Surprises Services means the following, to the extent covered under the Plan:

1. Out-of-Network Emergency Services;

2. Out-of-Network Air Ambulance Services;

3. Non-emergency Ancillary Services performed by an Out-of-Network Provider at an In-Network health care facility; and

4. Other Out-of-Network non-emergency services performed by an Out-of-Network Provider at an In-Network health care facility with respect to which the Provider does not comply with federal notice and consent requirements.

Recognized Amount means, with respect to an item or service furnished by an Out-of-Network Provider or Out-of-Network emergency facility, one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;

2. If there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or

3. If there is no applicable All-Payer Model Agreement or state law, the lesser of the amount billed by the Provider or facility or the Qualifying Payment Amount ("QPA").

For Air Ambulance services furnished by Out-of-Network Providers, the Recognized Amount is the lesser of the amount billed by the Provider or facility or the QPA.

Qualifying Payment Amount or QPA means generally the median contracted rates of the Plan for the item or service in the geographic region, calculated in accordance with 29 CFR Section 2590.716-6(c).

Serious and Complex Condition means one of the following:

1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent; or

2. In the case of a chronic illness or condition, a condition that is the following:

    a. Life-threatening, degenerative, potentially disabling, or congenital; and

    b. Requires specialized medical care over a prolonged period of time.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions, you may also call the Fund Office.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the Plan benefits.

The Board of Trustees (or its duly authorized designee) reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the Plan, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters, legal and/or factual, arising under the Plan.

UNITED WELFARE FUND

WELFARE DIVISION

IMPORTANT BENEFITS NOTICE
SUMMARY OF MATERIAL MODIFICATIONS

To: All Participants in the UNITED WELFARE FUND

From: Board of Trustees

Date: July 1, 2022

Re: Mental Health and Substance Abuse and Autism Spectrum Disorder Benefits

We are writing to advise you of important changes being made to the Mental Health and Substance Abuse and Autism Spectrum Disorder benefits rules of the UNITED WELFARE FUND (the "Fund**"). Please read this notice carefully since it could affect your and/or your dependents' benefits under the** Plan.

This document is a Summary of Material Modifications ("SMM") to the Fund's Summary Plan Description ("SPD"). We are sending it to you in accordance with federal law – the Employee Retirement Income Security Act of 1974, as amended (ERISA). Please take the time to read this SMM carefully, and please keep it with your copy of the SPD.

* * *

The Trustees of the Plan have taken the following actions by unanimous written consent, effective September 1, 2021.

A. The mental health or substance use disorder benefits in the Summary Plan Description for the United Welfare Fund - Welfare Division are amended to delete the following provisions from the Plan relating to coverage for residential treatment facility services:

1. Any limitation or exclusion to benefits based on a "fail first" requirement (such as a requirement to show that a lower level of care was not effective), as applied to the following classifications: (a) in-network outpatient; (b) out-of-network outpatient; (c) in-network inpatient; and (d) out-of-network inpatient.

2. Any limitation or exclusion to benefits based on a "likelihood of improvement requirement", as applied to the following classifications: (a) in-network outpatient; (b) out-of-network outpatient; (c) in-network inpatient; (d) out-of-network inpatient; and (e) emergency room services.

B. The Summary Plan Description for the United Welfare Fund - Welfare Division is amended to delete the following provision from the Plan relating to Autism Spectrum Disorders (ASD) services:

1. Any limitation or exclusions to benefits based on a "treatment plan requirement", for the following classifications: (a) in-network outpatient and (b) out-of-network outpatient; (c) in-network inpatient; and (d) out-of-network inpatient.

C. In place of the deleted provisions in Sections A and B above, benefit determinations for residential treatment and ASD services, respectively, shall be made under the Summary Plan Description for the United Welfare Fund - Welfare Division applying "medical necessity" criteria based on established guidelines (such as the MCG Health clinical decision guidelines).

* * *

Please call the Fund Office at (718) 658-4848 with any questions about these benefit changes.

This SMM is intended to describe certain changes being made to the plan of benefits ("Plan") of the UNITED WELFARE FUND. While every effort has been made to make this description as complete and as accurate as possible, this SMM does not contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this SMM and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). The Trust Agreement is available upon request at the above address and may be inspected by you free of charge during normal business hours.

No individual other than the Board of Trustees has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and to decide all matters arising under the Plan.

AMENDMENT TO THE
SUMMARY PLAN DESCRIPTION
FOR THE UNITED WELFARE FUND – WELFARE DIVISION

The Board of Trustees (the "Trustees") of the United Welfare Fund - Welfare Division (the "Plan") hereby amend the Summary Plan Description for the United Welfare Fund - Welfare Division (the "SPD"), as follows, October 1, 2022:

The SPD is amended, as follows:

1. SECTION 6: COVERED SERVICES is amended by replacing the existing sub-section N. Transplants with the following text:

N. Transplants

The Plan Covers only those transplants that are determined by the Plan's designated pre-authorization vendor to be medically necessary and appropriate as well as non-experimental and non-investigational. Covered transplants include, but are not limited to: kidney; corneal; liver; heart; pancreas; lung; bone marrow/stem cell transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome; transplant related Ventricular Assisted Devices (VADs).

For transplants, Participants in the Plan shall have access to the United Welfare Fund-specific transplant program which shall include portions of UnitedHealthcare's affiliate, United Resource Networks (U.R.N.) Transplant Network also known as the Optum's Transplant Commercial Centers of Excellence (COE).

Consistent with existing law, the Plan shall not cover the costs of transplants at facilities other than those included in the United Welfare Fund specific transplant program. The United Welfare Fund, as Plan Administrator, shall have full discretion on facilities to be included in their specific transplant program. In addition to the approval and designation by the preauthorization vendor for transplant medical necessity and appropriateness, the Plan Administrator shall have final approval on all transplants and the specific facilities where these procedures and services are to be performed.

Once approved as described above, the Plan will cover the hospital and medical expenses, including donor search fees, of the recipient.

The Plan will cover autologous bone marrow transplants combined with high dose chemotherapy, when medically appropriate, for the treatment of: advance neuroblastoma, second remission acute leukemia, relapsed Hodgkin's disease, relapsed non-Hodgkin's lymphoma, metastatic breast cancer, and other diagnoses that preauthorization vendor's Medical Advisory Board determines to be medically appropriate.

Subject to the provisions of the Plan, benefits will be provided for covered services furnished by a hospital which are directly and specifically related to the transplantation of organs, bones, tissues, or blood stem cells.

If a human organ, bone, tissue, or blood stem cell transplant is provided from a living donor to a human transplant recipient:

1. When both the recipient and the donor are Covered Persons or Eligible Dependents, each is entitled to the benefits under the Plan;

2. When only the recipient is covered, both the donor and the recipient are entitled to the benefits subject to the following additional limitations:
   a. 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 any government program; and
   b. Benefits provided to the donor will be charged against the recipient's coverage to the extent that benefits remain and are available after benefits for the recipient's own expenses have been paid.

3. When only the donor is a Participant or Eligible Dependent, the donor is entitled to the benefits under the Plan, subject to the following additional limitations:
   a. The benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Plan Document (Summary Plan Description), and
   b. No benefits will be provided to the non-Participant or non-Eligible Dependent transplant recipient.

4. If any organ, tissue, or blood stem cell is sold rather than donated to the Participant or Eligible Dependent recipient, no benefits will be payable for the purchase price of such organ, tissue, or blood stem cell; however, other costs related to evaluation and procurement are covered up to the Participant or Eligible Dependent Recipient's Plan limits for such costs.

5. The Plan does not Cover travel expenses, lodging, meals or other accommodations for recipients, donors, or guests.

6. The Plan does not Cover artificial organs.

The amendments contained herein shall be effective on October 1, 2022, and shall continue in effect thereafter until further action of the Trustees. Except as amended, all provisions of the SPD remain effective and unaltered.

Dated: October 1, 2022
New Rochelle, New York

Fund Administrator Signature

UNITED WELFARE FUND

WELFARE DIVISION

AMENDMENT TO THE UNITED WELFARE FUND DIVISION SUMMARY PLAN DESCRIPTION

The Plan Sponsor, United Welfare Fund, as the settlor of the Plan, amends the United Welfare Fund, Welfare Division Summary Plan Description (SPD). This Summary of amendments supplements the SPD previously provided to you. You should retain this document with your copy of the SPD.

Text of the Amendment

This Amendment updates the Plan Sponsor, Plan Administrator, and Agent for Service of Legal Process address to the following:

United Welfare Fund
145 Huguenot Street
Suite 100
New Rochelle, NY 10801

This amendment updates the Claims Administrator address to the following:

United Healthcare
UMR
P.O. Box 30541
Salt Lake City, UT 84130

Blue Cross
Leading Edge Administrators
8162 Woodland Center Blvd.
Tampa, FL 33614

This amendment updates the Claims Review and Appeals address to the following:

United Healthcare
United Welfare Fund
c/o UMR
Att: Appeals
P.O. Box 30546
Salt Lake City, UT 84130

Blue Cross
United Welfare Fund
c/o Leading Edge Administrators
Att: Appeals Department
8162 Woodland Center Blvd.
Tampa, FL 33614

In Witness Whereof, the Plan Sponsor has caused this Plan Amendment to be executed effective November 1, 2023.